STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daiszenia J. Allotey (Williams),
Petitioner,

vs. NO: 08 WC 33076

14IWCC0321

American Red Cross,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, medical expenses and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

14IWCC0321

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 1 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-04/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALLOTEY (WILLIAMS) DAISZENIA J
Employee/Petitioner

Case# **08WC033076**

06WC040169

AMERICAN RED CROSS
Employer/Respondent

14IWCC0321

On 3/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0834 KANOSKI & ASSOCIATES
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Daiszenia J. Allotey (Williams)
Employee/Petitioner

v.

American Red Cross
Employer/Respondent

Case # 08 WC 33076

Consolidated cases: 06 WC 40169

14IWCC0321

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on January 11, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **August 15, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was not*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$20, 800.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **one** dependent child.

Petitioner was temporarily totally disabled from **May 27, 2008** through **August 24, 2008**, a period of **12 6/7** weeks.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$3,191.62** in other benefits for which credit may be allowed under Section 8(j) of the Act, for a total credit of **$3,191.62**.

The parties agree that Respondent may have paid medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on August 15, 2006 that arose out of and in the course of her employment with Respondent, that timely notice of her alleged accident was provided to Respondent, or that her current condition of ill-being in her low back is causally connected to her alleged accident of August 15, 2006. Petitioner's claim for compensation is denied. No benefits are awarded.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of Arbitrator

3.5.13
Date

MAR 8 – 2013

This is one of two cases that were consolidated for purposes of arbitration; however, the parties requested that separate decisions be issued.

The Arbitrator finds:

Pre-Accident Events and Treatment

Petitioner testified that on March 21, 2005 she was working as a phlebotomist for the Central Illinois Community Blood Center. Petitioner testified that she was assisting a patient into a recliner. In doing so Petitioner was bearing the greater part of her weight and felt a pop in her back. [1] Petitioner testified that she experienced the onset of low and upper back and neck pain at that time. Petitioner testified she completed some paperwork and was seen by "their doctor," Dr. Bansal, that same day.

According to Dr. Bansal's records of March 21, 2005, Petitioner was transferring a donor to a recliner chair when she felt a pull in her right lower lumbar region. Petitioner's complaints included pain when bending forward and lifting. Petitioner denied any radiating leg pain, numbness, or tingling. Dr. Bansal noted palpable right lumbar tenderness and pain with motion of her back. Straight leg raise testing was negative bilaterally. Deep tendon reflexes were 2+ for Achilles and patellar. Dr. Bansal diagnosed Petitioner with a lumbar strain and prescribed medication and work restrictions of no lifting over 20 pounds. Petitioner was told to return to see him on March 25, 2005. (PX 6, p. 1; RX 1)

As instructed, Petitioner returned on March 25, 2005, reporting no improvement in her symptoms. Petitioner also reported considerable low back pain with some radiation of pain down her left leg to her knee. Bending forward or sitting for any period of time was still aggravating Petitioner's pain. Dr. Bansal again noted palpable lumbar tenderness and pain with motion. He continued her medications and her 20 pound lifting restriction but added that she should avoid frequent bending, squatting or kneeling and that she was to sit, stand or walk as tolerated. Petitioner was to return on April 5, 2005. (PX 6, p. 2; RX 1)

Petitioner testified that she provided these restrictions to the Blood Center but no work was offered to her within those restrictions, and she began receiving worker's compensation benefits. Petitioner testified that she also began therapy at Progressive Wellness at Dr. Bansal's direction on March 28, 2005. (PX 6, p. 8)

When initially evaluated at Progressive Wellness Center on the 28th Petitioner provided a history of transferring a blood donor from a wheelchair to another chair when Petitioner twisted her low back and heard and felt a popping sensation. . Petitioner's chief complaint was increased pain bilaterally in her low back with radiating symptoms into her right thigh. Petitioner denied any numbness or tingling but reported increasing difficulty with her ability to sleep and sit. Petitioner was currently sleeping on her side and only able to sit for an hour at a time. Petitioner reported full function prior to her accident. With regard to her job as a phlebotomist, Petitioner reported she engaged in moderate lifting. Petitioner was to be seen three times at which time additional recommendations from her treating physician would be elicited. (PX 6, pp. 9-10; RX 2)

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[1] This accident is the subject of claim 06 WC 40169 (Daiszenia J. Allotey (Williams) v, Central Illinois Blood Center)

Petitioner returned to Dr. Bansal on April 5, 2005, reporting she was doing better but still having pain from her lower back to mid-back region. Petitioner also reported that she could sit and stand for longer periods of time and denied radiating pain, numbness, or tingling at this time. She continued to have palpable lumbar tenderness on examination and pain with movement. Dr. Bansal continued her restrictions and medications. Dr. Bansal's diagnosis remained the same. Petitioner was to return on April 18, 2005. (PX 6, p. 3; RX 1)

Dr. Bansal re-examined Petitioner on April 18, 2005, with Petitioner reporting that overall she was improving, though she had localized pain at the L1/2 area on the left which seemed to tighten up and made it uncomfortable to sit or stand for long periods of time. Petitioner denied radiating pain down her legs or numbness or tingling. Petitioner's diagnosis remained the same. Dr. Bansal recommended trigger point injections over Petitioner's left latissimus dorsi area and they were performed during the visit. He modified her lifting restriction to 25 pounds but continued the rest of her restrictions. (PX 6, p. 4; RX 1)

Petitioner returned again to Dr. Bansal on April 29, 2005, as instructed, reporting continued low back pain that was radiating. She had not improved and was having difficulty sitting or standing. She had palpable thoracolumbar tenderness into her mid back and pain with movement of the back. Dr. Bansal recommended that she obtain a lumbar MRI and continued her work restrictions. (PX 6, p. 5; RX 2)

A lumbar MRI was performed on May 3, 2005, which showed moderately severe spinal stenosis at L4/5 secondary to a central subligamentous disc herniation as well as facet arthropathy, and a mild concentric disc bulging at L5/S1. (PX 6, p. 6)

After the MRI, Petitioner returned to see Dr. Bansal on May 6, 2005, reporting continued low back pain and pain radiating in to her right leg to the knee. She reported that it was uncomfortable to sit and stand for any period. Dr. Bansal noted palpable tenderness on examination and pain with movement of the back. Dr. Bansal's diagnosis was changed to an L5/S1 disc bulge. Due to her continued symptoms, Dr. Bansal referred Petitioner to Dr. Smucker. Dr. Bansal continued her work restrictions. (PX 6, p. 7; RX 1)

Throughout the foregoing time period Petitioner continued to participate in physical therapy at Progressive Wellness Center. When noted, Petitioner's effort was described as maximum and her compliance as full. Petitioner attended physical therapy on the following dates: March 28; March 30; March 31; April 4; April 6; April 7; April 11; April 13; April 14; April 18; April 20; April 22; April 25; April 27; and April 29, 2005. The only "Patient Daily Note" which contains any reference to Petitioner's neck or shoulder region is the one dated April 27, 2005, in which Petitioner reported that her neck and shoulder region and mid-back were sore from the new exercises. Overall Petitioner reported her low back was feeling fine. (PX 6, pp. 80 – 96)

Petitioner was initially examined by Dr. Smucker on May 9, 2005, reporting a history of injury while assisting in the transfer of a donor and feeling her back pop at that time. (PX 5, p. 51) Petitioner reported seeing Dr. Bansal that very day and noting a "re-exacerbation" of her symptoms four days later at which time she was rechecked and given work restrictions which could not be accommodated. Petitioner described her treatment with Dr. Bansal and noted that her symptoms had eased somewhat with therapy but her low back pain radiating into her thighs persisted. She reported that she had pain and tingling not only through her low back but also up through her thoracic back to her neck, shoulders and arms. She reported that the low back symptoms were the worst. Petitioner reported that sitting would exacerbate her symptoms the most, but that bending and standing were also uncomfortable. On examination, Dr. Smucker noted some tenderness throughout the thoracolumbar para-midline region bilaterally. He

reviewed the MRI and diagnosed Petitioner with lumbar degenerative disc disease with large subligamentous L4/5 disc herniation and resultant stenosis at that level, low back and thigh pain secondary to those findings and thoracolumbar complaints probably related to those findings, combined with soft tissue/myofascial pain. Dr. Smucker prescribed medication and an epidural steroid injection in Petitioner's lumbar spine. He placed her on restrictions of no lifting over 25 pounds, sit/stand option and no twisting or bending at the waist. He also directed Petitioner to resume therapy. (PX 5, pp. 51-53)

Petitioner underwent an epidural steroid injection at the L5 level on May 27, 2005, as well as continuing therapy at Progressive Wellness. (PX 5, pp. 44-49; PX 6, pp. 68-79)

Petitioner followed up with Dr. Smucker on June 1, 2005. Petitioner had stopped taking the Skelaxin and Mobic because she developed hoarseness and a sore throat. The lumbar epidural injection had resolved most of the pain radiating down into her legs; although, she still experienced fleeting radiating pain on occasion. Petitioner's low back pain was better but still ongoing, as was her thoracic pain. On examination, Petitioner had a negative neural tension sign on the right, equivocal on the left. There was no tenderness in palpating her low back but there was tenderness when palpating the thoracic back region on the left side. Dr. Smucker recommended a second injection, ongoing therapy, and continued work restrictions. (PX 5, p. 45)

Petitioner underwent a second injection on June 1, 2005. (PX 5)

Petitioner testified that the upper back, neck and arm pain that she described to Dr. Smucker had been present since the date of her accident, though Dr. Bansal had focused his treatment entirely on her low back, which had initially been a greater source of pain.

Petitioner presented to Springfield Clinic's Prompt Care on June 14, 2005 complaining of some neck swelling which started earlier in the evening. Petitioner described the location of the swelling as just above the collarbone in the area of her sternocleidomastoid area. She denied any pain. Petitioner reported that her muscles felt like they were straining as though she was holding something heavy. Petitioner denied any difficulty swallowing or breathing. She denied any radiating arm pain, numbness or weakness. Petitioner did report being treated for an ongoing back problem over the last three months and that she was currently undergoing physical therapy. Physical examination of Petitioner's neck revealed normal range of motion of her cervical spine without any pain. The attending doctor noted no edema, redness, swelling, or signs of infection. Petitioner displayed normal range of motion of her cervical spine without any pain. (RX 3) Cervical x-rays revealed no fracture, dislocation, or other acute anomaly. There was evidence of mild degenerative cervical spondylosis particarly at the C5-6 level with vertebral interspace narrowing and uncovertebral hypertrophy. (RX 3, p. 6) Dr. Campbell's assessment was swelling to the anterior neck, "not really appreciated on my exam." Petitioner was advised to continue her other medications and use ice a couple of times per day to help with the swelling. She should follow up with her doctor if no better or return to Prompt Care, as needed. (RX 3)

Petitioner presented to physical therapy on June 15, 2005, reporting that she had to go to Urgent Care on the 14th due to sharp pain in her neck in between her shoulder blades. Petitioner also reported a major increase in swelling in her neck/shoulder region. Petitioner was instructed to call her doctor immediately. Petitioner tolerated her treatments well without increased complaints of pain. No traction or new exercises were added due to her neck symptoms. (PX 6, p. 69)

Petitioner returned to Dr. Smucker's office on June 17, 2005, in a visit described as "urgent." Petitioner was complaining of swelling and pain in her neck, shoulder girdle, and extending into the bilateral upper extremities with radiating parasthesia. She reported that her low back and leg symptoms had quieted down some. Though Dr. Smucker did not observe swelling he indicated that a therapist had called and reported seeing swelling. He noted that cervicothoracic complaints had been present to various degrees since the reported injury and that her current symptoms suggested myofascial pain. Dr. Smucker noted that Petitioner's cervicothoracic complaints had been present to various degrees since the reported injury. The current intense pain Petitioner described was suggestive of cervicothoracic myofascial pain. He recommended an EMG/NCV to check for radiculopathy or neuropathy. He continued Petitioner's work restrictions, noting that Respondent had been unable to accommodate them so far. (PX 5, pp. 42-43)

Petitioner presented to physical therapy later in the day on the 17th. According to the daily note, Petitioner had just been seen by Dr. Smucker and was to undergo a test on her neck. Petitioner reported she had to leave early that day because she had an appointment scheduled with her primary care physician. Petitioner reported soreness n her low back. Petitioner did not complete all of her exercises due to her need to leave early. (PX 6, p. 68)

Petitioner underwent another therapy session on June 20, 2005. She described her low back pain as 1-2/10 and her upper back/shoulder pain as 4/10. Petitioner was still waiting for authorization to proceed with the EMG testing recommended by Dr. Smucker. (PX 6, p. 67)

Petitioner was seen at the Memorial Medical Center emergency room on June 21, 2005, reporting a history of a back injury on March 21, 2005. Petitioner had been evaluated by her family physician and Dr. Smucker and was initially started on Skelaxin and Mobic but was feeling "strange" and five days ago was switched to phenoprofen and amitryptiline. Petitioner reported persistent pain over her shoulder blades unrelieved by any medication. Petitioner described pain in her back and up to her neck, with swelling in her neck and pain across her shoulders and radiating into her left arm. (PX 7, pp. 7, 10) Petitioner was prescribed Decadron and Tramadol for pain. (PX 7, p. 8)

Petitioner testified at the arbitration hearing that this was the same pain she had been experiencing since her work accident, though it had become more intense without any new accident or injury.

Petitioner underwent physical therapy from June 24, 2005 through July 7, 2005. During this time Petitioner repeatedly reported that the swelling she was experiencing in her neck was due to the steroids she had been taking. (PX 6, pp. 64, 62) As of July 7, 2005, the therapist noted that Petitioner was reporting 85% improvement in her low back pain overall. Petitioner continued to note severe pain in her upper back into her left upper extremity with numbness and tingling; however, she was improving. Petitioner was discharged to a home program for her back. The doctor was asked to advise if anything more was to be done for Petitioner's neck. (PX 6, pp. 58-59; PX 5, p. 39)

At the request of Central Illinois Community Blood Center, Petitioner was examined by Dr. Michael Orth in Chicago on July 11, 2005. Petitioner testified that her TTD benefits ended as a result of that examination when Dr. Orth released her to work without restrictions. Petitioner testified that she did not return to work as Dr. Smucker still had prescribed work restrictions which Central Illinois Community Blood Center would not honor. Petitioner testified that Central Illinois Community Blood Center terminated her shortly after Dr. Orth released her.

Petitioner returned to see Dr. Smucker on July 27, 2005, at which time the doctor noted that the EMG/NCV study had been denied by the insurance carrier. He further noted that the insurance company had obtained an IME that indicated that Petitioner could return to full duty work. Petitioner continued to complain of cervical and upper thoracic pain with pain and paresthesia radiation into the upper extremities, left greater than right. Examination revealed a diminished biceps reflex on the left. Dr. Smucker's impression was lumbar degenerative disc disease with lower extremity symptoms improved with two epidural steroid injections and cervicothoracic complaints with upper extremity paresthesia and diminished left biceps reflex, suggesting a C5 or C6 radiculopathy. He continued to recommend the EMG/NCV as well as a cervical MRI. He provided work restrictions of no lifting over 25 pounds and no overhead work. He also recommended physical therapy 3 times per week. (PX 5, p. 38)

Petitioner underwent a Physical Therapy Initial Evaluation on August 2, 2005. According to the history, Petitioner reported a March 21, 2005 accident when she was transferring a patient from one wheelchair to another and she felt a pop and severe pain in her low back. She was treated with physical therapy and her low back pain was steadily improving. The history then states,

> However, she reports that on 6/15, while standing, she noted a sharp pain in between her shoulders [sic] blades extending up into the back of her neck. She states that later her neck and shoulders became very swollen, leading her to seek treatment at Prompt Care.
> (PX 5, p. 34)

Petitioner reported that her neck pain had continued to worsen while her low back pain had improved. Petitioner's primary complaint was mid-back and neck pain extending up into the back of her head and throughout both arms. Petitioner also reported "stinging at right arm" and "tingling and burning" at her left hand, along with giving away. Petitioner's lower extremity pain had resolved but some low back pain spasms continued. Petitioner's cervical movements were described as "guarded." No edema or ecchymosis was visualized. Petitioner was to be seen two to three times per week for 3 -4 weeks, initially. (PX 5, p. 34-36)

An MRI of Petitioner's cervical spine was obtained on August 6, 2005, showing degenerative disc and endplate osteophytic changes on the right at C3/4 and C5/6 with right greater than left foraminal narrowing at those levels. An MRI of Petitioner's thoracic spine showed minimal bulges present in the mid thoracic spine at T2/3, 3/4 and 4/5 with no cord impingement. The radiologist concluded that the scan was "essentially unremarkable". (PX 5, pp. 29-30) Petitioner underwent EMG/NCV testing by Dr. Smucker on August 19, 2005 which showed a mild C6 radiculopathy and no evidence of any peripheral neuropathies. (PX 5, pp. 24-28)

Petitioner's Progress Note from Progressive Wellness Center dated August 24, 2005 stated Petitioner had given maximum effort and full compliance during the reporting period. Petitioner was not responding well to physical therapy at that time as Petitioner was noting increased pain in her cervical spine and low back which she rated a 6-7/10. Despite attempts with distraction and myofascial techniques, Petitioner was unable to tolerate. She was noted to be performing a pain-free exercise program. (PX 5, p. 23)

Petitioner returned to Dr. Smucker on August 26, 2005. He noted that Petitioner continued to complain of cervical and thoracic pain and pressure as well as paresthesia into both upper extremities. He noted she had work restrictions but had been terminated from her job. On physical examination, Dr. Smucker

noted a decreased left biceps reflex. He noted that the cervical MRI had shown disc-osteophyte complexes at C3/4 and C5/6. He continued her work restrictions and recommended cervical epidural steroid injections. Petitioner was not taking any medications. (PX 5, p. 21)

Petitioner had a left C7/T1 epidural steroid injection on September 12, 2005. (PX 5, p. 19)

Petitioner's September 23, 2005 Progress Note from physical therapy indicated Petitioner was noting temporary improvement in her neck pain as a result of physical therapy. "Very minimal objective" improvement in cervical range of motion was noted. Petitioner was scheduled for another injection in the upcoming week. (PX 5, p. 18))

Dr. Smucker re-examined Petitioner on October 7, 2005. Dr. Smucker noted that Petitioner had experienced no improvement with the first injection so the second planned injection was cancelled. He further noted she had been set up for an appointment to see Dr. VanFleet. Physical therapy was to be continued. She was placed back on Tizanidine, which helps her sleep at night. Petitioner's ongoing complaints included pain in her neck and trapezius areas and into both arms to the fingers, especially the index and middle fingers of the hands. He noted that her symptoms were initially on the left side and were now on both sides. His impression was cervical radiculopathy and cervical degenerative disc disease with osteophyte complexes as noted and some flattening of the cord. Petitioner's work restrictions were continued but her physical therapy sessions were decreased. (PX 5, p. 17)

As of October 6, 2005, Petitioner was reporting significant temporary relief of pain with her physical therapy treatments. However, with any increased activity level, her pain would return. Petitioner had progressed in her therapy, however. (PX 5, p. 14)

Dr. Timothy VanFleet examined Petitioner at Dr. Smucker's request on October 19, 2005. In connection with the examination, Petitioner completed a "Spine Sheet." Petitioner's primary problem was listed as pain and swelling in the cervical area and periodic low back pain. Petitioner stated that her first episode of pain began on March 21, 2005 as a result of an injury/accident. She listed "March 21, 2005" as the date of accident and identified her "Back" as the part of the body she injured. Petitioner denied any prior back or neck trouble. Petitioner described the accident as follows:

> 3-21-05 I was working at Central IL Comm. Bld Cntr.
> Donor had bad reaction. I helped transfer donor from
> w/c to recliner. I lifted upper body during transfer,
> back popped very hard. Pain started in my lower back
> radiated down left leg. Also had pain in upper back.
> Pain increased in upper back 6.15.05."
> (PX 5, p. 4)

Petitioner further stated that her most recent episode had started on June 15, 2005 and she went to the emergency room. Petitioner provided additional information concerning the nature of her pain, its location on a pain drawing, and its severity (7/10). (PX 5, pp. 4-7)

When examined by Dr. VanFleet, Petitioner's complaints included difficulty with neck pain and bilateral radiating arm pain. Petitioner had evidence of multilevel cervical degenerative disc disease without any evidence of focal neurologic compression. He did not feel she was a surgical candidate at the present time as he didn't believe her symptoms would respond well to an operation. He emphasized the importance of

continued non-operative care with a structured physical therapy program. Petitioner provided a consistent history of her initial accident with a pop in her back and pain in her back and leg as well as neck pain. She reported that her symptoms in her back and leg were intermittent and of lesser concern. These had responded well to injections. She described pain and swelling in her interscapular area and paresthesias in her upper extremities. Dr. Van Fleet felt that Petitioner was suffering from multilevel degenerative disc disease but did not feel that she was a surgical candidate. He recommended that she continue with active stretching and exercise. (PX 5, pp. 11–13)

Petitioner saw Dr. Smucker on the same date. He noted Dr. Van Fleet's conclusions. Petitioner reported to him that she had been terminated from her job and she was planning to return to Peoria, Illinois and seek work there. Dr. Smucker released Petitioner to full duty, full-time work, and stated "I feel that we have done everything that I know to do to try and help and therefore, I consider her to have achieved maximum medical improvement." She was to continue Tizanidine at bedtime. (PX 5, p. 10)

Petitioner telephoned the physical therapist on October 20, 2005, to notify Progressive that she was cancelling the remainder of her appointments as she was moving out of town and had been released by her doctor. (PX 6, p. 27)

Petitioner testified that she continued to experience pain in her low back, upper back and neck after her release by Dr. VanFleet. Petitioner changed jobs on November 22, 2005, going to work for Respondent in Peoria, Illinois. Petitioner testified that this job involved attending blood drives and moving equipment associated with those drives.

Post-Accident Events, Treatment, and Testimony

Petitioner testified that on or about August 15, 2006, while attending a blood drive in Galesburg, Illinois, she was moving a piece of heavy equipment that was on wheels up a ramp onto a lift of a truck. As the equipment was being moved it started to roll and she reached out and grabbed it and pulled it back onto the truck's platform, resulting in a sudden increase in her lower and upper back and neck pain. Petitioner testified that she filled out paperwork with Respondent to report this incident as a workers' compensation case. Petitioner testified that she had consulted with an attorney about this incident and had completed paperwork to be sure that proper notice was given within the 45 day statutory period.

Petitioner filed her Application for Adjustment of Claim against Central Illinois Community Blood Center on September 15, 2006. Petitioner claimed she was transferring a patient on March 21, 2005 when she injured her back and neck. (AX 2)

Petitioner underwent no medical treatment between October 19, 2005 and September 21, 2006.

On September 21, 2006, Petitioner presented to Dr. Richard Kube at the Midwest Orthopedic Center in Peoria, complaining of upper back and neck pain. (PX 1, p. 310) Petitioner testified that this was the earliest appointment that she was able to obtain after her August 15, 2006 accident. A new patient information sheet completed by Petitioner is silent concerning an alleged August 15, 2006 accident. (RX 3) According to the records Petitioner had been having some problems with upper back and neck pain for about a year and that the problems began when she was moving a patient at her former job with Central Illinois Community Blood Center. Petitioner reported she was now working for Respondent and continuing to have some problems. Petitioner expressed concern that she might lose her job. "This is a litigious issue work comp claim from previous." At this time Petitioner was working as phlebotomist for

Respondent. Petitioner was noted to be married, but living alone. On examination, Dr. Kube noted that Petitioner walked with an antalgic gait, but did not have signs of myelopathy. He noted that she had pain in her back with a right-sided Spurling's maneuver. He noted that she had some point tenderness in her upper thoracic spine at mid-line. X-rays on that date showed diffuse degenerative change in her thoracic and cervical spine. She showed some cervical spondylosis at C3/4 and C5/6. He recommended physical therapy and an MRI and noted that steroid injections may be required. An MRI was taken on September 25, 2006, showing multi-level degenerative changes in Petitioner's cervical spine, worse at the C3/4 and C5/6 levels. (PX 1, pp. 306-307) It was noted that there was moderate proximal right neuroforaminal stenosis at C3/4, and moderate to severe right neuroforaminal stenosis at C5/6. (PX 1)

Petitioner underwent an initial physical therapy evaluation at the Midwest Orthopedic Center on September 26, 2006. Petitioner's presenting diagnoses included cervicalgia, joint stiffness in the neck, and muscle weakness. She reported that her recent problem had started while at work as a phlebotomist when she was pushing something heavy and heard a pop in her low back. She reported that pain was now radiating into her upper back and neck and that the problem had been aggravated by her new job as phlebotomist for Respondent pushing and lifting heavy objects. Petitioner wished to get the pain under control and avoid surgery. Petitioner was tearful during the evaluation, worried about losing her job, undergoing a divorce, and living with her granddaughter who she took care of. Petitioner sated "she noticed the pain started at the same the major life changes of the move and the separation from her husband took place." Her doctor tried to medicate her for depression but she declined noting she could not tolerate the medication due to her sensitivity to medicine. (PX 1, pp. 303-304)

Petitioner returned to Dr. Kube on October 16, 2006, who noted the MRI results. He recommended another round of steroid injections to see if that would help alleviate her nerve pain, and also recommended an EMG to localize the source of her pain. (PX 1, p. 299)

An EMG was performed on October 24, 2006 by Dr. Yibing Li finding bilateral mild carpal tunnel syndrome and bilateral ulnar neuropathy at the wrists. (PX 1, pp. 293-297) He noted that there were some findings suggesting early or mild cervical radiculopathy bilaterally at C5/6 and C6/7 but the findings were not definitive. [not related.]

At the request of Dr. Kube, Petitioner was seen by Dr. Demaceo Howard on October 26, 2006. Dr. Howard records a history of "persistent pain following a work-related injury in which her low back was involved." Petitioner had been treated with both lumbar epidural steroid injection and cervical injections. Petitioner reported improvement with the injections in her low back but not her neck. He noted that she has continued gainful employment without any significant interruption and noted that the recent EMG findings that did not explain her ongoing pain. Dr. Howard performed a physical examination. He concluded that she was suffering from non-radicular neck pain with evidence of disc degeneration and facet arthropathy and bone spur complex. He felt that she was suffering from possible facet arthropathy or discogenic neck pain. He planned to proceed with a medial branch block. (PX 1, pp. 290-291)

Petitioner underwent medial branch blocks at the C3,4 and 5 levels on December 7, 2006 on the right and on December 15, 2006 on the left at the Methodist Medical Center. (PX 4, pp. 9, 38) Petitioner returned to Dr. Howard on January 3, 2007, reporting that her neck pain was about 50% better, but still present. (PX 1, p. 260) Dr. Howard recommended conservative treatment with Ultram and Skelaxin and directed to follow up on a PRN basis.

Petitioner returned to Dr. Kube on January 18, 2007, reporting continued pain in her neck and shoulders. (PX 1, p. 248) She also reported some occasional pain in her right upper extremity. She reported that she had not experienced any real significant relief from the injections in her neck. Based upon her MRI and EMG findings, Dr. Kube stated that he did not think that there was a surgical intervention that would relieve her symptoms at that point, and released her from care to return as needed.

Petitioner testified that she continued working and continued to experience the same pain in her neck that she had experienced since her initial accident.

On September 21, 2007, Petitioner was seen by Dr. John Mahoney for complaints of right wrist pain that had been present for the past 6 to 8 weeks. (PX 1, pp. 240-241) As part of the examination Petitioner completed a Medical History Questionnaire (PX 1, pp. 244 – 245) In the Questionnaire, Petitioner listed her chief complaint as pain in her right wrist and thumb which had started six weeks earlier. Petitioner listed her employer as Respondent. She denied having injured herself on the job.

Dr. Mahoney noted that Petitioner had previously been seen by Dr. Kube for complaints of neck pain that "seems to be a different problem." Her biggest problem was reportedly radial-sided wrist and thumb pain. (PX 1, p. 240) Dr. Mahoney believed Petitioner had right De Quervain's tenosynovitis and he recommended a steroid injection which Petitioner underwent that same day. Petitioner followed up with the doctor on October 19, 2007 at which time Petitioner reported the injection had helped a lot but she was not completely cured. Petitioner denied any numbness or tingling in her hand. (PX 1, p. 239) Petitioner testified that she pursued treatment through Dr. Mahoney for treatment of her hands, which is the subject of another claim not now before the Arbitrator.

Petitioner returned to see Dr. Mahoney on January 15, 2008. At that time he diagnosed Petitioner with recurrent right wrist DeQuervain's tenosynovitis and bilateral carpal tunnel syndrome with superimposed cervical radiculopathy. (PX 1, pp. 236-237) Dr. Mahoney injected the first dorsal compartment of Petitioner's right wrist and the carpal tunnel of Petitioner's left wrist. Dr. Mahoney also referred Petitioner to Dr. Mulconrey to assist him in determining how much of her symptoms were coming from her neck versus how much was coming from the median nerve compression in her carpal tunnel.

When Petitioner returned to Dr. Mahoney on January 29, 2008, she reported that the DeQuervain's injection had helped a little but that the carpal tunnel injection to the left wrist had not helped much. She still complained of tingling in her median nerve digits bilaterally. She also reported some pain radiating down from her neck into her shoulders as well. He opined that's he may benefit from surgery on her DeQuervain's, and that she may be suffering from a double crush effect with both her neck and carpal tunnel compressions contributing to the numbness and tingling in her fingers. She was to see Dr. Mulconrey in the next couple of weeks. (PX 1, p. 235)

Petitioner did see Dr. Mulconrey initially on February 11, 2008. (PX 1, pp. 232-233) His history noted that she had been involved in a work accident in June of 2005 with recurrent problems since that time. She reported axial neck pain rated at 4.2/10 and upper extremity pain at 6/10. Her pain was worse in her right arm than her left. She reported pain in her bilateral trapezial region, right shoulder, upper arm and both hands. Raising her arm would worsen her pain. She also reported weakness in her right hand and intermittent paresthesia in the lateral three digits bilaterally. She reported occasional headaches that were moderate but frequent. On examination, he noted decreased sensation in her bilateral lateral forearms, and decreased strength on the right in her biceps, triceps, wrist flexors and extensors when

compared to the left. X-rays showed bilateral uncinate spurring at C5/6, mild degenerative disc disease at C3/4 and mild uncinate spurring on the left at C6/7. Dr. Mulconrey diagnosed multilevel cervical spondylosis, degenerative disc disease and bilateral upper extremity radiculopathy. He opined that Petitioner had foraminal stenosis with radicular symptoms that was causing her decreased sensation and strength. He ordered an MRI of her cervical spine which was done on February 14, 2008 and showed multilevel spondylosis C3 through C6 with uncinate spurring and disc bulging, and borderline central stenosis at all three levels. (PX 1, p. 215) Foraminal narrowing was also present, worse at C5/6 and C3/4. There was also a left paramedian protrusion at C6/7.

Petitioner returned to Dr. Mulconrey on March 21, 2008. (PX 1, p. 213) He reviewed the MRI results and recommended an anterior cervical decompression and fusion. He noted that she had experienced some relief with the previous injections by Dr. Howard. (PX 1, p. 212) He felt that the pain that Petitioner was experiencing in the right hand was related to problems at C5/6. Dr. Mulconrey saw Petitioner back for a pre-operative review of the procedure on May 7, 2008, (PX 1, p. 200) and then proceeded with surgery on May 27, 2008 at OSF St Francis consisting of an anterior cervical decompression and fusion at C5/6. (PX 2, pp. 6-7)

Petitioner followed up with Dr. Mulconrey on June 16, 2008, reporting some difficulty swallowing after surgery that was improving. (PX 1, p. 196) Dr. Mulconrey noted that she was to remain off work and directed her to start physical therapy. Petitioner returned on July 23, 2008, and was noted to be doing well overall, but was still complaining of interscapular pain which Dr. Mulconrey expected to improve as her fusion solidified. (PX 1, p. 194) She also complained of continued intermittent upper extremity radiculopathy, and complained that she was having occasional problems with her voice. Dr. Mulconrey noted that her problems with her voice could be related to her cervical surgery, but that he anticipated they would improve. Petitioner returned to Dr. Mulconrey again on August 27, 2008, reporting improvement in her interscapular pain, but complained of swelling on the left anterior portion of her neck in the supraclavicular area. (PX 1, p. 103) She also reported improvement in her voice and Dr. Mulconrey noted that a laryngoscopy had been done by an ENT and found no evidence of vocal cord paralysis. (See PX 3, pp. 81-86) She was given a 25 pound lifting restriction and advised to return in three months. However, Petitioner testified that, at her urging, the Dr. Mulconrey released her without restrictions at that time so that she could return to work.

Petitioner returned to Dr. Mulconrey on November 19, 2008, overall doing well, but reporting a recent increase in her mid-scapular pain. (PX 1, p. 100) Her upper extremity radiculopathy had nearly resolved. X-rays indicated that instrumentation was in appropriate position, but that the superior portion of the graft was not yet completely healed. Dr. Mulconrey continued her Neurontin and directed her to return for a one-year follow-up. Petitioner returned on May 20, 2009, reporting that she was doing well overall but was having intermittent pain in her cervical spine. (PX 1, p. 92) X-rays showed proper positioning but there was some question as to whether the upper end plate had completely fused. Dr. Mulconrey prescribed Flexeril, a Medrol dose pack as well as Naprosyn. He noted that she was having considerable lumbar based symptoms that might require therapy.

Petitioner filed an Application for Adjustment of Claim against Respondent on July 28, 2008. Petitioner alleged she injured her neck on August 15, 2006 while "pushing." (AX 4)

Petitioner underwent no treatment between November 19, 2008 and April 25, 2011.

Petitioner returned again to Dr. Mulconrey on April 25, 2011, three years following her cervical fusion. (PX 1, p. 49) Petitioner reported that she continued to suffer axial neck spasms but no significant upper extremity pain or symptoms. Petitioner did, however, describe significant low back pain, with symptoms in her lumbar spine and bilateral buttocks. Petitioner reported having difficulty at work and a recent incident where she had bent over and had difficulty straightening back up. On examination, Petitioner had some limitation in lumbar extension and a mildly positive straight leg raising test. Dr. Mulconrey diagnosed spondylolisthesis by x-ray examination, spinal stenosis and lumbar spondylosis. He prescribed physical therapy, injections by Dr. Sureka and Neurontin and Naprosyn. (PX 1, p. 49) Petitioner saw Dr. Sureka on the following day, April 26, 2011, reporting a six year history of low back and right leg pain. (PX 1, pp. 46-47) She reported that the pain traveled along the right anterior thigh and was worse with walking or bending. Dr. Sureka diagnosed possible lumbar radicular pain with low back and leg pain and recommended an MRI of her lumbar spine and physical therapy. Records show that Petitioner began a course of physical therapy on April 29, 2011. (PX 1, pp. 43-44) The MRI performed on May 2, 2011, showed anterolisthesis at L4/5 with moderate central canal stenosis in combination with facet arthropathy and ligamentum flavum hypertrophy. It also showed a broad based disc protrusion at L3/4 with moderate neural foraminal narrowing and impingement of the exiting nerve at L3. (PX 1, pp. 63-64)

Petitioner returned to Dr. Sureka on May 4, 2011, reporting that her buttock and leg pain had improved but her low back pain remained the same, and was exacerbated by bending or prolonged walking. (PX 1, p. 41) After reviewing the MRI, Dr. Sureka recommended a course of right L4 transforaminal epidural steroid injections, Gabapentin and continued therapy. Petitioner did undergo epidural steroid injections on June 1, 2011 (Left L5), June 8, 2011 (Right L4) and June 22, 2011 (Left L5). (PX 1, pp. 65-68) Petitioner returned to Dr. Sureka on July 13, 2011, reporting that the third epidural steroid injection did not give significant relief. (PX 1, p. 13) She reported cramping pain in her leg and continued low back pain. She reported that bending, standing and walking tended to worsen her pain. Dr. Sureka recommended a bone scan and use of Cyclogenzaprine three times daily for symptom relief. (PX 1, p. 13) A bone scan was done on July 18, 2011, but did not reveal significant abnormalities other than "mild facet osteoarthritic osteoblastic activity in the lower lumbar region at L3 to S1". (PX 1, p. 75) Dr. Sureka's office recommended referral to a surgeon (PX 1, p. 11) but the suggestion was not pursued at that time as Petitioner was beginning a new job. (PX 1, p. 10)

Petitioner offered the evidence deposition of Dr. Daniel Mulconrey, an orthopedic spine surgeon taken on March 29, 2010. Dr. Mulconrey testified that since he saw Petitioner some time after her accidents had occurred he had difficulty relating specific findings on the MRIs to her work accidents, as they could be either acute or chronic changes. (PX 10, pp. 16-17) However, he testified that a tugging or pulling type of injury can aggravate these conditions in the cervical spine. (PX 10, p. 18) He testified that such conditions can be aggravated by accidents without significant changes on the MRI. (PX 10, p. 19) He also testified that findings as he had found on the MRIs can be present without symptoms. (PX 10, p. 20) He testified that if a patient with such changes is symptom free and then develops symptoms in connection with a work accident, those accidents would be considered contributing causes for her need for surgery. (PX 10, p. 21) He testified that based upon a hypothetical question describing both work accidents, it would be difficult, if not impossible, to separate the two and give an opinion as to the relative contribution of each accident to her condition. (PX 10, p. 21) Dr. Mulconrey acknowledged having given Petitioner off work slips dated June 16, 2008 and July 23, 2008, the latter keeping her off work until her next appointment in 4 or 5 weeks. (PX 10, p. 23, Pet Depo Ex. 2 and 3).

On cross-examination by counsel for Respondent, Dr. Mulconrey testified that Petitioner's complaints and pain diagram that Petitioner provided initially to Dr. Van Fleet on October 16, 2005, could be consistent with the findings that he observed on the MRI in 2008. (PX 10, p. 28) He also testified that the pain diagram that Petitioner completed for Dr. Kube when Petitioner saw him on September 21, 2006, could be consistent with the condition for which the he performed surgery on May 27, 2008, though the pain diagram was different than the one completed for Dr. Van Fleet. (PX 10, p. 29) Dr. Mulconrey testified that the findings on the MRI dated September 25, 2006 could be present absent any traumatic event. (PX 10, p. 32) He testified that he could not determine the age of the findings without seeing pervious MRI studies, though the finding of a right paracentral disc protrusion could possibly be an acute finding. (PX 10, p.33) Based upon a review of records presented to him by Respondent's attorney, Dr. Mulconrey testified that the symptoms that Petitioner described to him appeared to relate to the March 2005 incident. (PX 10, p. 39) Based upon those records, he opined that the surgery that he performed could have been required absent any other inciting factor beyond that initial incident in March 2005. (PX 10, pp. 39-40) Dr. Mulconrey testified under cross-examination by Central Illinois Blood Bank's attorney that comparing the MRI that he had performed in 2008 and the report of the MRI done in 2006 it appeared that the findings were similar. (PX 10, p. 50)

Central Illinois Community Blood Center offered the deposition of Dr. Michael Orth who examined Petitioner pursuant to Section 12 of the Illinois Workers' Compensation Act on July 8, 2005. Dr. Orth claimed in his report and deposition testimony that Petitioner indicated to him that her neck pain began on June 15, 2005. (See RX 4, p. 7) He opined that Petitioner had suffered an acute lumbosacral strain at the time of her first work injury that was superimposed upon a pre-existing degenerative arthritis with spinal stenosis at L4/5. (RX 4, p. 9) Dr. Ortho opined that her low back condition had reached maximum medical improvement by the time of his examination. (RX 4, p. 10) Dr. Orth testified that Petitioner had a normal examination regarding her cervical region though she had an unidentified condition in her supraclavicular area. (RX 4, p. 10-11) Dr. Orth did state that Petitioner had some tenderness in the paraspinal muscle mass, the trapezius and upper half of the thoracic paraspinal musculature. (RX 4, p. 13) Dr. Ortho opined that the complaints that Petitioner had in her cervical area and supraclavicular area were not related to her work accident in March 2005. (RX 4, p. 14) Dr. Orth admitted on cross-examination that if he accepted the history to Dr. Smucker of cervical and thoracic complaints since the reported injury, he would have to relate those complaints to the accident. (RX 4, pp. 16-17) He also acknowledged that the type of accident that she described in lifting a patient would be consistent with an injury that would cause such cervical complaints. (RX 4, p. 17) He also acknowledged that his findings of cervical paraspinal muscle mass tenderness were consistent with a problem in the cervical spine. (RX 4, p. 17) Dr. Orth testified that his current practice is limited to doing independent medical evaluations and that he had retired from clinical practice in December 2004. (RX 4, p. 18) He testified that his examinations are nearly 100% at the request of respondents. (RX 4, p. 19) Dr. Orth testified that when he was in active orthopedic practice, he did not do neck surgery. (RX 4, p. 19) Upon further cross-examination, Dr. Orth acknowledged that Petitioner was off work at the time of his examination and he did not release her to return to work. (RX 4, p. 26) He acknowledged that Petitioner had complaints of numbness in her hands and tingling sensations that could be an abnormality associated with one of the cervical nerve roots. (RX 4, pp. 23-24)

Respondent offered the deposition of Dr. Marshall Matz taken on May 26, 2010. Dr. Matz testified that Petitioner had reported to him that she injured her back on August 15, 2006, near the end of her work day as a phlebotomist, when she was loading a piece of equipment onto a vehicle and the equipment started to roll backwards and she attempted to stop it and injured her back. (RX 7, p. 7-8) He stated that he asked Petitioner whether she had any prior treatment to her back or spine and she denied any similar

conditions or complaints in the past. (RX 7, p. 8) Dr. Matz testified that medical records contradicted this statement, showing "a variety of spinal complaints and specifically complaints involving her neck and limbs" going back to early 2005. (RX 7, p. 8) He confirmed that an injury date of May 21, 2005 contained in his report may be a typographical error. (RX 7, p. 8-9) Dr. Matz testified that records of Dr. Bansal dated April 29, 2005 and of the Orthopedic Center of Illinois dated May 9, 2005 show spinal complaints. (RX 7, pp. 9-10) He testified that complaints reflected in the office note of June 17, 2005, from the Orthopedic Center of Illinois were consistent with cervical radiculopathy preceding her accident at American Red Cross. (RX 7, p. 10) Dr. Matz testified that complaints at the Orthopedic Center of Illinois on July 27, 2005, of radiating paresthesia and diminished biceps reflex would be consistent with some nerve root irritation of the C5/6 level pre-dating Petitioner's accident in 2006. Dr. Matz noted that a history in a physical therapy note of August 2, 2005, of the onset of pain between the shoulder blades on June 15, 2005 that extended to her neck followed by swelling in the neck and shoulder could refer to referred pain from the neck. (RX 7, p. 12) Dr. Matz testified that decreased cervical range of motion and strength, with stinging pain in the right arm and tingling down the left described in that note could be consistent with cervical radiculitis. (RX 7, p. 12) Dr. Matz testified that complaints of pain in the neck, trapezius and both arms noted in an Orthopedic Center of Illinois note of October 7, 2005 show further pre-existing symptoms. (RX 7, p. 13) In reviewing findings on a cervical MRI of August 6, 2005, Dr. Matz testified that the findings on C3/4 to the right were an incidental finding, but that findings at C5/6 with left foraminal narrowing could be the source of Petitioner's neck and arm complaints. (RX 7, pp. 13-14)

Dr. Matz testified that findings on an EMG of August 19, 2005 demonstrated a C6 radiculopathy that pre-existed her accident with Respondent, and was consistent with her prior reference to a diminished reflex. (RX 7, p. 14) Dr. Matz testified that the Orthopedic Center of Illinois note of August 26, 2005, showing complaints of cervical and thoracic pain and pressure and paresthesia in the bilateral upper extremities were further evidence of a pre-existing chronic condition. (RX 7, pp. 14-15) Dr. Matz noted that the initial treatment note of Dr. Kube on September 21, 2006, after Petitioner's accident of August 15, 2006, referred to neck and upper back pain that had been present for about a year and started while moving a patient at a former job, and did not refer to any new accident. (RX 7, p. 15-16) He reviewed the intake note for that appointment, noting that it referred to an accident date of March 21, 2005 and that her complaints had been going on for a year. (RX 7, pp. 16-17) Dr. Matz testified that he reviewed the film of the MRI of September 25, 2006, and testified that there was no significant change from the prior film and that he did not feel that it showed any acute findings. (RX 7, p. 17) Dr. Matz also testified that he had reviewed a record of Dr. Howard dated October 26, 2006, and noted that there was no history of an August 15, 2006 occurrence. (RX 7, p. 19) Dr. Matz was also directed to the office note of Dr. Mulconrey of February 11, 2008, and noted that the history referring to an accident in June 2005, referred to long standing issues long pre-dating August 2006. (RX 7, p. 19) He confirmed that her complaints at that time were similar to those voiced in 2005. (RX 7, p. 19) Dr. Matz's attention was also directed to the history form completed at the time of the February 11, 2008 visit with Dr. Mulconrey referring to neck pain and that had been present since June 2005, and testified that this was also consistent with long standing pre-existing complaints. (RX 7, p. 20) Dr. Matz testified that the radiology findings of the MRI taken on February 14, 2008, were similar to the MRI findings in 2005 and testified that there were no acute findings on that scan that would be attributed to the incident of August 25, 2006. (RX 7, pp. 20-21)

Dr. Matz testified that in his opinion there was no causal connection between Petitioner's work-related accident of August 15, 2006, and her treatment starting with Dr. Kube on September 21, 2006 and subsequent surgical intervention on May 27, 2008. (RX 7, p. 24) On cross-examination, Dr. Matz confirmed that the degenerative conditions as found in Petitioner's spine can be aggravated by incidents of lifting or pulling heavy objects as she described, where a history relates no prior symptoms and a

sudden onset of symptoms related to the incident. (RX 7, p. 30) Dr. Matz acknowledged that some patients with such MRI findings would not have symptoms and that surgery would be performed only associated with symptoms that affect the patient's quality of life. (RX 7, pp. 31-32) Dr. Matz testified that he has not done surgeries for five years and that currently 30 percent of his practice is related to performing medical-legal examinations. (RX 7, pp. 33-34) He testified that he does a couple exams per month for Respondent's counsel's firm. (RX 7, pp. 34-35)

Petitioner also offered the evidence deposition of Dr. Paul Smucker taken on March 3, 2011. Dr. Smucker testified that when he saw Petitioner initially on May 9, 2005, she was reporting pain, not only in her low back, but also pain and tingling radiating up the thoracic back and into the neck, shoulder and arms. (PX 9, p. 6) Her primary complaint at the initial visit was of the pain in her low and mid back. (PX 9, p. 6) Following examination, Dr. Smucker diagnosed lumbar degenerative disc disease with a large broad based midline L4/5 disc herniation causing stenosis. He felt that the low back and thigh pain was related to that herniation. He also felt she had some soft tissue or muscle pain. (PX 9, p. 8) Dr. Smucker recommended use of Mobic and Skelaxin, and suggested an epidural steroid injection series. (PX 9, pp. 8-9) Dr. Smucker placed Petitioner on a 25 pound lifting restriction and recommended that she avoid twisting or bending at the waist. (PX 9, p. 9) Petitioner had the first epidural steroid injection and saw Dr. Smucker on June 1 and Dr. Smucker's impression at that time was that she had lumbar degenerative disc disease and a disk herniation at L4/5 that was somewhat improved by the initial injection. (PX 9, p. 10) Petitioner had a second injection on June 6, 2005 and then returned to Dr. Smucker earlier than scheduled on June 17, 2005, reporting pain and swelling in her neck, shoulder girdle and arms with radiating numbness and tingling. She reported improvement in her low back and legs after the two epidural steroid injections. (PX 9, p. 11) Dr. Smucker noted that the cervicothoracic complaints had been present to varying degrees since the reported injury. He noted she had intense pain coming on intermittently on either side which he felt was consistent with myofascial pain, but ordered an upper extremity EMG to check for radiculopathy or neuropathy. (PX 9, pp. 12-13) When seen on July 27, 2005, Petitioner showed a diminished biceps reflex on the left side though other neurological testing was normal. (PX 9, pp. 13-14) Dr. Smucker felt that the diminished biceps reflex could be consistent with a radiculopathy. (PX 9, p. 14) Dr. Smucker again recommended an EMG as well as a cervical MRI. (PX 9, p. 14) An MRI was done on August 6, 2005, that showed osteophytic change and degenerative disk changes on the right at C3/4 and C5/6 with right greater than left neuroforamina narrowing at both levels. (PX 9, p. 15) An EMG was done on August 19, 2005, that showed a mild left C6 radiculopathy. (PX 9, p. 15) Dr. Smucker testified that the EMG findings were consistent with the clinical finding of diminished reflex and stenosis at C5/6 shown on the MRI. Petitioner returned to Dr. Smucker on August 26, 2005, with continuing complaints, and Dr. Smucker recommended continued work restrictions, therapy and a cervical epidural steroid injection. (PX 9, pp. 16-17) The epidural injection on October 7, 2005, provided no improvement and an appointment was set with Dr. VanFleet, with continued physical therapy. (PX 9, pp. 14-15) Petitioner was complaining of pain in her neck and in the muscles between her shoulder blades and radiating in to her arms and fingers. Her symptoms were on both sides rather than primarily on the left. (PX 9, pp. 18-19) Petitioner returned to Dr. Smucker on October 19, 2005 after having seen Dr. VanFleet that day. Dr. VanFleet had not felt that she required operative intervention at that time. Dr. Smucker's diagnostic impression remained the same, being cervical radiculopathy and degenerative disc disease. (PX 9, p. 20) As Petitioner was not considered an operative candidate, Dr. Smucker felt that he had done all he could do and released Petitioner at maximum medical improvement and to return to work. (PX 9, pp. 20-21)

Dr. Smucker opined that Petitioner's low back complaints were causally related to her first work-related accident. (PX 9, p. 21) Dr. Smucker also opined that the cervical complaints that he treated were causally related to her work accident. (PX 9, p. 22) Dr. Smucker acknowledged that he had reviewed records of Petitioner's subsequent treatment that he detailed in his report attached as Exhibit 2 of his deposition, and included Petitioner's subsequent cervical fusion at C5/6. (PX 9, pp. 22-23) Based on those records and his knowledge of Petitioner's initial treatment, Dr. Smucker opined that Petitioner's cervical fusion was causally related to her March 2005 accident. (PX 9, p. 23) Dr. Smucker acknowledged that the subsequent diagnoses of Petitioner's cervical conditions as well as her complaints were consistent with what he had diagnosed. (PX 9, p. 24) On cross-examination, Dr. Smucker acknowledged that on June 17, 2005 Petitioner appeared seeking treatment for her neck and upper back, but volunteered that she had complained of her neck, shoulder girdles and upper extremities on the first day he saw her, though the degree of complaint was greater at the subsequent visit. (PX 9, pp. 32-33) He testified that throughout his treatment Petitioner had "consistently any time we reviewed the question of how did this all begin, each time she indicated that all of the above symptoms, the low back, the neck, the upper back and all that stuff began with this incident of a pulling in her back the day she was transferring someone" referring to the incident of March 21, 2005. (PX 9, pp. 33-34) Addressing his release of Petitioner without restrictions, Dr. Smucker commented, "I would also point out that this individual was leaving the community, and I have no doubt that I would have confided in her and asked her if she wanted me to give her any restrictions because we were at the end of the road and she was moving to a new community and she was hoping to find work there. And both she and I would have known that her going to a new community and having work restrictions could have made it very difficult for her to find a job." (PX 9, p. 38) Dr. Smucker reviewed the initial treatment records from Dr. Bansal and Progressive Wellness and acknowledged that they contained no reference to complaints of the neck. (PX 9, pp. 29-30) However, Dr. Smucker testified later that Petitioner and her doctors may have been focused on her then primary complaint of low back pain, just as Dr. Smucker had focused on the complaint primarily in his first visit with Petitioner, though he did note her complaints in her neck and upper extremities. (PX 9, pp. 42-45) Dr. Smucker testified that the notes that he reviewed from Dr. Bansal did not change his opinion on causation, and that he had noted that there were other medical issues that Dr. Bansal did not refer to, which would suggest the low back complaints were being focused upon to the exclusion of other present issues. (PX 9, pp. 47-48)

Petitioner testified that she continues to experience spasms and pain in her neck and low back. Petitioner testified that she no longer performs many of her household duties and that her children have taken over many of them due to her pain. Petitioner testified that she currently works as a phlebotomist for Central Illinois Cancer Care which involves only drawing blood and does not involve the lifting and moving of equipment that she was required to do previously. Petitioner testified that she avoids activities involving bending or lifting over 10 pounds. She no longer drives long distances as this exacerbates her low back and neck pain. She limits climbing stairs. Petitioner testified that she takes over-the-counter-pain medication daily for her pain.

The Arbitrator concludes:

Accident.

Petitioner failed to prove she sustained an accident on August 15, 2006. Petitioner's testimony as to accident was not corroborated by or consistent with any of the medical records generated after her alleged accident and prior to her filing her workers' compensation claim against Respondent. While there is a vague general reference to "pushing and lifting heavy objects" in the September 26, 2006 physical therapy note, that is different that the very specific occurrence Petitioner described in her testimony. Petitioner was not a credible witness.

Notice.

Petitioner failed to prove she provided timely notice of her alleged August 15, 2006 accident to Respondent. Petitioner testified that she completed some papers within 45 days and that a lady named "Mary" was to get the papers. Petitioner could not recall her title. Petitioner testified she did not retain or get a copy of the report she gave to Mary. Petitioner bears the burden of proving timely notice of the accident was given. In this instance Petitioner could not establish exactly when she gave notice or to whom she provided notice. Petitioner failed to meet her burden of proof.

Causation.

Even assuming Petitioner had established she sustained an accident on August 15, 2006, Petitioner's claim for compensation must be denied as she failed to prove that her current condition of ill-being in her neck and low back is causally related to that accident. Petitioner continued to work after the alleged accident on August 15, 2006. She could not recall exactly when it occurred that day. Thereafter, she continued to work her regular schedule and sought no treatment until September 21, 2006. A close inspection of the medical records generated after the alleged accident fails to reveal any mention of an August 15, 2006 accident. Petitioner either doesn't mention any accident or references an accident in March of 2005. The Arbitrator further notes Petitioner's testimony that at the time of the alleged August 15, 2006 accident she experienced "increasing" back pain as she was still supposedly experiencing low back and neck pain from an earlier accident in 2005. At most (and assuming an accident occurred) Petitioner may have sustained a temporary exacerbation of her underlying neck condition; however, she did not undergo much treatment (physical therapy and a visit with Dr. Kube) before embarking on care and treatment for her unrelated right hand/wrist/thumb problems. Petitioner also had some substantial gaps in treatment in 2007 and from 2008 through 2011. Petitioner never mentioned an accident with Respondent or one occurring in August of 2006 while treating with Dr. Mulconrey or Dr. Sureka.

Petitioner's claim for compensation is denied. No benefits are awarded. All other issues are rendered moot.

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STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Brenning,
Petitioner,

vs. NO. 10 WC 36220

State of Illinois,
Menard Correctional Center.
Respondent.

14IWCC0322

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering, the issues of accident, causal connection, temporary total disability, permanent partial disability, medical expenses, prospective medical expenses and notice and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 15, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAY 0 1 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-04/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRENNING, LARRY
Employee/Petitioner

Case# **10WC036220**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

14IWCC0322

On 7/15/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 15 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Larry Brenning
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 10 WC 36220

Consolidated cases: ____

14IWCC0322

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on May 8, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On September 10, 2010, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did not sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $57,108.00; the average weekly wage was $1,098.23.

On the date of accident, Petitioner was 56 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, Petitioner's claim for compensation is denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec p. 2

July 8, 2013
Date

JUL 15 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury to his right and left arms/shoulders arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of September 10, 2010. Respondent disputed liability on the basis of accident, notice and causal relationship. Petitioner's counsel also filed a petition for Section 19(k) and Section 19(l) penalties and Section 16 attorneys' fees

Petitioner was employed by Respondent as a Correctional Officer from February 23, 1987, until he retired in December 30, 2010, a period of almost 24 years. Petitioner testified that his job duties were the same as what he testified to in a prior repetitive trauma case involving his hands/elbows. A copy of the decision that was rendered in that case was received into evidence at trial (Petitioner's Exhibit 9). Petitioner also prepared a hand-written description of his job duties which was also received into evidence at trial (Petitioner's Exhibit 10). According to Petitioner's hand-written job description, from 1987 to 1992, Petitioner worked in a cell gallery with each gallery containing at least 48 cells. Petitioner would bar rap, used keys, carried food racks and trays, carried ice buckets and containers. Petitioner would also sweep/mop the galleries and pick up trash. Petitioner's statement also indicated that he worked in the tower and that he would inventory ammunition, transport weapons to the armory and would, on occasion, be removed from the tower and assigned to a gallery. At the conclusion of Petitioner's hand-written statement, he noted "In summary I would say I used my shoulders, hands and elbows extensively, especially the first 14 years of my working career." Petitioner's testimony was that for the first 14 years as a Correctional Officer, he worked primarily in the cell galleries performing the tasks generally associated with that assignment. For the remaining 10 years (approximately 2000 to 2010), Petitioner worked primarily in the tower. Petitioner did state that he worked a substantial amount of overtime and, on those occasions, he was generally not working in the tower but in the prison galleries. When the facility was on a "lockdown" Petitioner was usually removed from the tower and assigned to pass out the food trays in the galleries. Petitioner testified that in 2008, 2009 and 2010, the facility was on lockdown for approximately 250 days. Respondent introduced into evidence a record of those lockdowns for those years. The Arbitrator has reviewed the record and is not able to determine with any certainty the precise number of times the facility was on lockdown (due to various codes contained in the document); however, the actual number of days the facility was on lockdown appears to be approximately 100.

Petitioner testified that in the course of performing his job duties, in particular, the last 10 years that he worked for Respondent, that he began to develop symptoms in his elbows/wrists as well as his shoulders. Petitioner testified that when the facility was on lockdown that there was no inmate movement and that he was required to carry trays up and down stairs and in the galleries and that this specific activity caused his shoulders to hurt and become symptomatic. Petitioner testified that while he was experiencing this gradual onset of pain that he simply "...put up with the pain."

Petitioner did not seek any medical treatment for his shoulder problems until he was seen by Dr. George Paletta, an orthopedic surgeon, on September 10, 2010. At that time, Petitioner informed

Dr. Paletta that the onset of symptoms occurred approximately five years ago, and that the primary activity that caused shoulder pain was carrying the racks of trays with food weighing various amounts. Petitioner testified that this procedure involved a significant amount of repetitive lifting from chest to shoulder level.

Dr. Paletta examined the Petitioner and noted positive findings in respect to the AC joints. His preliminary diagnosis was probable distal clavicle osteolysis of both shoulders. In his medical report of that date, Dr. Paletta opined that based on the history Petitioner provided to him and his job requirements that the bilateral shoulder problems were either caused or aggravated by Petitioner's work activities. Dr. Paletta had MRIs performed on September 10, 2010, of both shoulders. The MRI of the right shoulder revealed tendinopathy of the infraspinatus and subscapularis tendons, AC arthrosis and swelling of the AC joint. The MRI of the left shoulder had essentially the same findings as the right with the exception that the swelling of the AC joint was more significant than what was observed on the right.

Dr. Paletta subsequently reviewed the MRI of the right shoulder on September 15, 2010, and opined that it revealed significant AC joint inflammation, distal clavicle edema and AC joint arthrosis. Dr. Paletta initially recommended conservative treatment and referred Petitioner to Dr. Matthew Bayes, an orthopedic surgeon associated with him, who saw Petitioner on October 1, 2010. Petitioner also informed Dr. Bayes of the gradual onset of his bilateral shoulder symptoms over the preceding five years. Dr. Bayes gave Petitioner injections in both of his shoulders.

On September 29, 2010, Petitioner completed a "Notice of Injury" in which he indicated a date of injury September 10, 2010, and that Petitioner injured his shoulders by "Turning keys, packing trays, closing doors." (Respondent's Exhibit 1). On that same date, Major R. D. Moore completed the "Supervisor's Report of Injury or Illness" which indicated that Petitioner had injured both shoulders while performing repetitive motions through turning keys, packing trays and closing doors (Respondent's Exhibit 3).

Petitioner's bilateral shoulder conditions were unresponsive to conservative treatment so Dr. Paletta performed arthroscopic surgeries on the right and left shoulders on January 4, and March 17, 2011, respectively. In both instances, the surgical procedure consisted of a subacromial decompression, bursectomy and acromioplasty with distal clavicle excision. Following the surgeries, Petitioner received physical therapy and was released to full activity on June 13, 2011.

At the direction of the Respondent, Petitioner was examined by Dr. James Emanuel, an orthopedic surgeon, on August 1, 2011. Petitioner informed Dr. Emanuel that for the first 10 years of his employment his primary job was carrying trays up/down stairs and that he would, on occasion, lift the trays from waist to shoulder height. Petitioner advised Dr. Emanuel that for the last 14 years on the job, he was primarily in the tower and occasionally in the galleries when he would be required to feed the inmates. Dr. Emanuel examined Petitioner, reviewed both of the MRIs and the medical treatment records. Dr. Emanuel opined that Petitioner's work duties did not cause or aggravate the bilateral shoulder condition noting that during Petitioner's last 14 years of employment he was primarily in the tower and very little activity that involved the repetitive use of the upper extremities was, in fact, required and that Petitioner only occasionally participated in the movement of the trays. He also noted that the duration of symptoms reported

to both Dr. Paletta and Dr. Bayes was five years but that it was 10 years, when he examined the Petitioner.

On August 31, 2011, Petitioner was seen by Dr. Paletta and his condition was improved. Although Petitioner had retired at that time, Dr. Paletta opined that Petitioner could return to full unrestricted duties and that he was at MMI. Dr. Paletta was deposed on April 19, 2013, and his deposition testimony was received into evidence at trial. Dr. Paletta testified that he diagnosed Petitioner with arthritis and osteolysis of the clavicle. When questioned about osteolysis, Dr. Paletta stated that it develops as a result of an inflammatory response at the distal end of the clavicle, typically due to repetitive stress. It is a somewhat common situation or condition for individuals that do a substantial amount of weightlifting. Dr. Paletta opined that Petitioner's job duties of carrying trays and pushing/pulling cell doors were a contributing cause of the condition.

Dr. Emanuel was deposed on December 20, 2011, and his deposition testimony was received into evidence at trial. Dr. Emanuel's testimony was consistent with his medical report and he reaffirmed his opinion that there was not a causal relationship between Petitioner's bilateral shoulder condition and the work activities. Dr. Emanuel specifically noted that Petitioner only performed a minimal amount of repetitive activities during the last 14 years of his employment for Respondent.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to his right and left arms/shoulders arising out of and in the course of his employment for Respondent and that his current condition of ill-being in regard to the right and left shoulders is not causally related to his work activities.

In support of this conclusion the Arbitrator notes the following:

The time of the initial onset of Petitioner's bilateral shoulder symptoms cannot be determined with any reasonable certainty because Petitioner informed Dr. Paletta and Dr. Bayes that the shoulder symptoms began five years prior to their examinations (September and October, 2010, respectively); but when seen by Dr. Emanuel in August, 2011, Petitioner stated that the symptoms began 10 years prior.

The Petitioner spent the last 10 years of the time he worked for Respondent (approximately 2000 to 2010) working in the tower. While he performed some of the tasks that he believed caused his bilateral shoulder problems, the evidence does not support that he did so on any regular and continuous basis.

In the Report of Injury Petitioner stated that turning keys, carrying trays and closing doors caused his shoulder problems; however, the evidence does not support that he performed these various activities on any continuous and repetitive basis for the last 10 years that he worked for Respondent.

Petitioner's statement that he simply lived with bilateral shoulder pain for a period of 10 years before seeking any medical treatment is not credible.

The Arbitrator finds the opinion of Dr. Emanuel to be more persuasive than that of Dr. Paletta, primarily because Dr. Emanuel's opinion was based on a more complete and accurate understanding of Petitioner's work activities.

In regard to disputed issues (D), (E), (J), (L) and (M) the Arbitrator makes no conclusions of law because these issues are rendered moot because of the Arbitrator's conclusions in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Corey Jackson,
Petitioner,

vs. NO. 11 WC 37264

14IWCC0323

Southern Illinois University,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering, the issues of temporary total disability, the nature and extent of Petitioner's disability, medical expenses and choice of Petitioner's physician and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 17, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

14IWCC0323

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 1 2014

Daniel R. Donohoo

o-03/26/14
drd/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

JACKSON, COREY
Employee/Petitioner

Case# 11WC037264

14IWCC0323

SOI/SOUTHERN ILLINOIS UNIVERSITY
Employer/Respondent

On 7/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0478 EDWARD J FISHER
1300 SWANWICK ST
PO BOX 191
CHESTER, IL 62233

0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

0558 ASSISTANT ATTORNEY GENERAL
MOLLY WILSON DEARING
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 17 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Corey Jackson
Employee/Petitioner

v.

State of Illinois/Southern Illinois University of Carbondale
Employer/Respondent

Case # 11 WC 37264

Consolidated cases: ____

14IWCC0323

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on May 10, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Exceeded choice of physicians and mileage

FINDINGS

On May 17, 2011, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is not causally related to the accident.

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $1,438.48.

On the date of accident, Petitioner was 33 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $305.50 to SIU-Carbondale Student Health Program, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Arbitrator's Conclusions of Law attached hereto, all other compensation benefits are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 15, 2013
Date

JUL 17 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on May 17, 2011. According to the Application, Petitioner fell off the back of a work truck while strapping a gang box and sustained injuries described as "Multiple - spine." Respondent stipulated that Petitioner did sustain a compensable accident on May 17, 2011; however, Respondent disputed liability on the basis of causal relationship. Respondent also took the position that Petitioner had exceeded the choice of physicians as prescribed by the Act. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits, medical bills, mileage and prospective medical treatment.

Petitioner worked for Respondent as an electrician and was hired out of the Union Hall in West Frankfort to perform electrical work on the campus of Southern Illinois University. On May 17, 2011, Petitioner was in the process of loading what he described as a "gang box" and was putting it in the back of a truck. While performing this task, Petitioner stepped onto a "Tommy gate," a lifting device attached to the back of the truck. When the gate stopped moving, Petitioner backed up and fell backwards into one of the gate's steel supports. Petitioner submitted into evidence a photo of the truck with the gate in place and Petitioner circled the support that he landed on when he fell (Petitioner's Exhibit 12). Petitioner testified that when he fell, his shirt was ripped and he sustained a scrape/cut on his low back. The accident was reported in a timely manner and the "Notice of Injury" was completed and signed by Petitioner on May 20, 2011, in which he described the injury as being a "scrape on my lower back." A "Supervisor's Report of Injury or Illness" was prepared by Tom Clark, Petitioner's supervisor, on May 23, 2011, and it also described the injury as being a scrape of the low back. (Respondent's Exhibits 2 and 3).

Following the injury, Petitioner was taken to the SIU Medical Clinic where he was seen by Dr. Melodi Ewing, who noted that Petitioner had a five cm abrasion in the mid-line of the lumbosacral area of the back with some mild tenderness. X-rays of the lumbosacral spine were obtained which were normal and the Petitioner was directed to call if he was not better.

The Petitioner's family physician was Dr. Bharat Patel who had previously treated him for a variety of health issues, including muscular spasms of the back. Dr. Patel's medical records indicated that Petitioner was seen for muscular back spasms on December 1 and December 22, 2010, as well as March 31, 2011. Dr. Patel prescribed Flexeril for this condition. At trial, Petitioner testified that he had no prior low back symptoms and that the prior treatment that he had received from Dr. Patel was for the upper back and shoulder blade areas.

Petitioner was seen by Dr. Patel for the first time subsequent to the accident on May 31, 2011. Petitioner testified that he had not scheduled an appointment and that he simply went to the doctor's office. Petitioner's primary reason for seeing Dr. Patel at that time was for bilateral knee pain and an anxiety disorder, both of which were conditions for which he was previously treated by Dr. Patel. There was no reference to the accidental injury of May 17, 2011, or any back symptoms or complaints. Petitioner testified that he did inform Dr. Patel of his back problems at that time and had no explanation as to why it was not contained in the medical record.

Petitioner was seen by Dr. Patel on July 14, 2011, which was a routine scheduled appointment to have his testosterone levels checked. Dr. Patel's record of that date also contained the notation of muscular spasm; however, it is not clear if this was in reference to the back or not. Petitioner was seen again by Dr. Patel on August 5, 2011, again primarily because of his testosterone level. There was no reference in either record to the work accident of May 17, 2011.

Petitioner continued to work full duty for Respondent as an electrician until August 26, 2011, when his temporary job for Respondent ended. Subsequent to the cessation of employment, Petitioner was seen by Dr. Patel again on September 6, 2011, and, for the first time, Dr. Patel's record of that date indicated that in May, 2011, Petitioner fell off of a truck and hit his low back and that he was treated at Student Health Services and had an x-ray. At trial, Petitioner testified that his back was sore even though he continued to work full duty as electrician.

Dr. Patel ordered an MRI without IV contrast and one was performed on September 13, 2011, which revealed degenerative changes, foraminal narrowing and some disc bulges. On September 14, 2011, Dr. Patel reviewed the MRI and opined that it revealed no acute trauma. Dr. Patel noted that Petitioner complained of low back pain but there were no radicular complaints. Dr. Patel authorized Petitioner to be off work and ordered a second MRI with IV contrast which was performed on September 16, 2011. The findings of this second MRI were consistent with the findings of the one that had just been performed two days prior. Dr. Patel referred Petitioner to Dr. K. Brandon Strenge, an orthopedic surgeon.

Dr. Strenge saw Petitioner on September 22, 2011, and Petitioner provided him with a history of the work-related accident of May, 2011, and advised that he had complaints of low back pain. Dr. Strenge's findings on clinical examination of the low back revealed no tenderness, a negative straight leg raising test and symmetrical neurological findings at both the ankles and knees. Dr. Strenge reviewed the MRI and noted that it revealed an enhanced lesion at L1-L2; however, he noted "I do not see any pathology on his MRI that would elicit any further back pain." Dr. Strenge opined that the lesion could be a hematoma so he referred him to Dr. Theodore Davies, who saw Petitioner on October 11, 2011. In regard to Petitioner's low back, Dr. Davies' findings on clinical examination were consistent with those of Dr. Strenge; however, he noted an area of hyperpigmentation in the low back consistent with a hematoma and referred Petitioner to Dr. Matthew McGirt of the Vanderbilt Spine Institute.

Dr. McGirt examined Petitioner on November 16, 2011. In connection with that evaluation, Petitioner completed an information sheet in which he described the circumstances of the work-related accident and that he had been experiencing symptoms for three and one-half months, which indicated an onset date of sometime in August, 2011. Petitioner informed Dr. McGirt of having sustained a fall on his back in May and having chronic low back pain but that he had no leg pain or numbness/tingling. Dr. McGirt reviewed the MRI and noted that it showed no structural abnormalities in the low back. In regard to the lesion, Dr. McGirt opined that it was either an ependymoma or schwannoma, but that it was not responsible for any of his back symptoms. In regard to the low back, Dr. McGirt stated that Petitioner had a back strain/sprain and recommended that he have some physical therapy and use a back brace.

Petitioner was seen by Dr. Strenge on December 13, 2011. Dr. Strenge opined that Petitioner's pain was muscular myofascial and he had Petitioner continue with physical therapy and authorized him to remain off work. Dr. Strenge saw Petitioner again on January 10, 2012, and, on physical examination, there was no tenderness of the lumbar paraspinals, straight leg raising was negative bilaterally and the neurological findings were symmetric at both the ankles and knees. Dr. Strenge authorized Petitioner to remain off work and ordered continued physical therapy. On February 23, 2012, Dr. Strenge recommended Petitioner transition from physical therapy to work hardening.

Dr. Strenge referred Petitioner to Dr. Monte Rommelman, a physiatrist, who initially saw Petitioner on February 29, 2012. Petitioner complained of low back pain and stated that his symptoms began in May, 2011, following a fall at work. Dr. Rommelman recommended Petitioner have some epidural steroid injections at L4-L5 and that he continue physical therapy. Dr. Rommelman gave Petitioner steroid injections at L4-L5 on May 1 and May 22, 2012, but Petitioner's condition did not improve. When Dr. Rommelman saw Petitioner on June 13, 2012, Petitioner informed him that his pain was worse.

At the direction of the Respondent, Petitioner was examined by Dr. Kevin Rutz, an orthopedic surgeon, on April 5, 2012. In connection with his examination of the Petitioner, Dr. Rutz reviewed the medical records of the providers who had previously treated the Petitioner. Dr. Rutz's findings on examination revealed a full range of motion of the back, normal strength and reflexes and a negative straight leg raising test. Petitioner informed Dr. Rutz that he did not have pain following the accident of May 17, 2011, but that he experienced a slow gradual onset of pain sometime thereafter. Dr. Rutz reviewed the MRIs and opined that they were unremarkable in regard to the lumbar spine. Dr. Rutz opined that the accident of May 17, 2011, resulted in a skin abrasion. Dr. Rutz further opined that given the fact that Petitioner did not experience an onset of pain at the time and did not seek medical care for several months the accident was not a causative factor of his current condition of ill-being. Dr. Rutz further opined that Petitioner was at MMI and could return to work without restrictions.

On November 19, 2012, Petitioner was seen by Dr. Matthew Gornet, an orthopedic surgeon. Petitioner informed Dr. Gornet of having sustained the injury on May 17, 2011, and the medical treatment that he received thereafter. Dr. Gornet opined that Petitioner's symptoms may have been related to a subtle disc injury at L4-L5 versus an aggravation of pre-existing facet arthritis at that level. He further opined that Petitioner's symptoms were related to the accident of May 17, 2011. Dr. Gornet ordered that a new MRI be performed and he authorized Petitioner to return to work on light duty with no lifting over 35 pounds. On January 14, 2013, Petitioner underwent an MRI which suggested the presence of a nerve sheath tumor at L1-L2 and a broad based disc protrusion at L4-L5, probably a partial annular tear. Dr. Gornet saw Petitioner on that date and recommended that he have some facet blocks at L4-L5. Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell who performed nerve blocks on Petitioner on January 23, and February 6, 2013. Petitioner was again seen by Dr. Gornet on February 25, 2013, and informed him that the injections did help but that the pain had returned. Dr. Gornet ordered that Petitioner have a CT/myelogram which was performed on April 22, 2013, and revealed facet changes at L4-L5.

In April, 2013, Dr. Rutz reviewed additional medical records including those of Dr. Gornet. Dr. Rutz prepared a supplemental report dated April 30, 2013, in which he reaffirmed his opinion that Petitioner's back pain was not causally related to the accident of May 17, 2011. Dr. Rutz stated that the timeline of Petitioner's complaints was consistent with a long-standing degenerative condition and not any acute trauma.

Dr. Strenge was deposed on September 13, 2012, and his deposition testimony was received into evidence at trial. Dr. Strenge testified that he initially saw Petitioner on September 22, 2011, and that Petitioner's symptoms were the result of a myofascial strain which he related to the accident of May 17, 2011. Dr. Strenge agreed that his opinion regarding causality was based on the history provided to him by the Petitioner and that he relied on the fact that Petitioner had experienced an immediate onset of pain following the accident. He further agreed that if the records indicated that Petitioner did not sustained an immediate onset of pain following the accident and was able to continue to work, that he could have potentially changed his opinion in regard to causality. He also stated that if Petitioner had back problems prior to May 17, 2011, that this could also cause him to potentially change his opinion in regard to causality.

Dr. Patel was deposed on October 18, 2012, and his deposition testimony was received into evidence at trial. Dr. Patel testified that Petitioner had been a patient of his since August, 2007, and that Petitioner had degenerative joint disease which was symptomatic prior to May, 2011. While Dr. Patel opined that the accident of May 17, 2011, aggravated this pre-existing condition, he agreed that an onset of pain/symptoms three months post accident would be inconsistent with a traumatic event.

Dr. Rommelman was deposed on October 18, 2012, and his deposition testimony was received into evidence at trial. Dr. Rommelman testified that there was a causal relationship between the accident of May 17, 2011, and the Petitioner's low back condition; however, this opinion was based on the Petitioner having an immediate onset of pain at the time of the accident continuing until the time he saw him. Dr. Rommelman was not aware that Petitioner had back pain from 2007 to 2011 and that he had not sought any medical treatment until three months following the accident and that he had continued to work.

Dr. Rutz was deposed on May 3, 2013, and his deposition testimony was received into evidence at trial. Dr. Rutz's testimony was consistent with his medical reports and he reaffirmed his opinion that there was not a causal relationship between Petitioner's low back condition and the accident of May 17, 2011. Dr. Rutz noted that the Petitioner's timeline of not seeking any medical treatment until three and one-half months following the accident was consistent with a degenerative condition with a slow gradual onset as compared to an acute trauma. Further, when Dr. Rutz read the MRIs he noted that other than some degenerative changes, but there was nothing revealed which would account for Petitioner's subjective pain complaints other than those degenerative changes.

Petitioner testified that he had no prior symptoms in regard to his low or middle back prior to May 17, 2011, and that the treatment he received for muscular spasms was in the upper area of the back between the shoulder blades. Petitioner agreed that he worked continuously from May 17, 2011, through August 26, 2011, when he was laid off from the job. He stated that during this

period of time, he experienced back complaints while performing his job duties but that he did not seek any treatment from a physician. Petitioner admitted to having received some disability payments through his union and receiving unemployment compensation benefits for a period of time. Petitioner testified that he is presently unable to do anything that requires any physical exertion.

Jennifer Batson testified on behalf of the Respondent. Ms. Batson is the Respondent's Workers' Compensation/Disability Coordinator who handles all of the necessary paperwork for both occupational and non-occupational employee disability claims. Batson confirmed that Petitioner reported the accident in a timely manner. She confirmed that Petitioner's job was a temporary assignment that ended on Friday, August 26, 2011, and that Petitioner called her on Monday, August 29, 2011, requesting that she approve treatment for his May, 2011, back injury.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's current condition of ill-being is not causally related to the accident of May 17, 2011.

In support of this conclusion the Arbitrator notes the following:

While there is no dispute that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on May 17, 2011, Petitioner continued to work in a full unrestricted capacity until his job with Respondent ended on August 26, 2011. Petitioner sought no medical treatment for any back issues during this period of time. Although Petitioner was seen by his family physician, Dr. Patel, on May 31, July 14 and August 5, 2011, he did not inform Dr. Patel of having sustained a work-related back injury nor did he have any complaints of low back symptoms. Further, Dr. Patel previously treated Petitioner for muscular spasms in the back and agreed that Petitioner had degenerative changes in his back that pre-existed the accident of May 17, 2011.

Petitioner's testimony that he experienced back symptoms immediately following the accident of May 17, 2011, is not credible and contradicted by his failure to report any back symptoms to Dr. Patel until September 6, 2011, and his advising both Dr. McGirt and Dr. Rutz that the onset of symptoms occurred sometime in August, 2011, or gradually developed over a period of time, respectively. Additionally, the unrebutted testimony of Jennifer Batson raised significant doubts as to Petitioner's credibility in that she testified Petitioner called her the Monday following the ending of his temporary assignment requesting that she approve treatment for his May, 2011, back injury.

The opinions of Dr. Patel, Dr. Strenge and Dr. Rommelman in regard to causality are significantly flawed because they are based upon incomplete and inaccurate history regarding the onset of Petitioner's symptoms. However, all three of these physicians agreed that a gradual onset of pain was inconsistent with a traumatic event.

The opinion of Dr. Rutz is the most persuasive, primarily because it is the only opinion that is based upon the correct information regarding Petitioner's medical treatment, history and onset of symptoms. Dr. Rutz's opinion that Petitioner's treatment and report of a gradual onset of pain subsequent to the accident is consistent with the degenerative condition as opposed to an acute traumatic event.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner received reasonable and necessary medical treatment immediately following the accident of May 17, 2011, and that Respondent is liable for payment of the medical bill associated therewith. All other bills for medical services are denied.

Respondent shall pay reasonable and necessary medical services of $305.50 to SIU-Carbondale Student Health Program, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In regard to disputed issues (K), (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusions in regard to disputed issue (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Summers,
Petitioner,

vs. NO. 12 WC 02257

14IWCC0324

Republic Waste,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering, the issues of accident, temporary total disability, permanent partial disability, medical expenses and prospective medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 1, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

14IWCC0324

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 01 2014

Daniel R. Donohoo

o-04/22/14
drd/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

SUMMERS, DAVID
Employee/Petitioner

Case# 12WC002257

14IWCC0324

REPUBLIC WASTE
Employer/Respondent

On 5/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1580 BECKER SCHROADER & CHAPMAN PC
NATHAN A BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

4942 LEAHY WRIGHT & ASSOCIATES
KEVIN M LEAHY
10805 SUNSET OFFICE DR STE 306
ST LOUIS, MO 63127

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Summers
Employee/Petitioner

v.

Republic Waste
Employer/Respondent

Case # 12 WC 2257

Consolidated cases: ___

14IWCC0324

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **3-19-13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS **14IWCC0324**

On the date of accident, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$51,057.76**; the average weekly wage was **$981.88**.

On the date of accident, Petitioner was **43** years of age, *single* with **0** children under 18.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $654.58/week for 54 and 2/7 weeks, commencing 3/12/2012 through 3/27/2013, as provided in Section 8(b) of the Act. The parties stipulated that Petitioner was paid all owed TTD benefits from the date of accident until 3/11/2012.

Respondent shall pay reasonable and necessary medical expenses, pursuant to the medical fee schedule of $765.00 to Dr. Rhunda El-Khatib, as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive an 8(j) credit for any amounts actually paid to medical providers by Respondent's group insurance. Respondent shall hold Petitioner harmless in keeping with Sections 8(j).

Respondent shall authorize and pay for the reasonable, necessary and related medical treatment proposed by Petitioner's treating physician, including appropriate surgical intervention to Petitioner's lumbar spine.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

4/29/13
Date

ICArbDec19(b)

MAY - 1 2013

14IWCC0324

Findings of Fact

Petitioner is a 44 year-old diesel mechanic for Respondent. On October 4, 2011 Petitioner sustained an injury to his low back. Specifically, Petitioner was working under a diesel truck, laying-flat on his back on a creeper board, maneuvering a torch rod. As he was positioning the torque-rod he twisted and felt a pop in his back and immediately felt pain in low back. Petitioner continued to work the rest of his shift. He testified that throughout the rest of the work day, he had to do substantial bending over at the waist, which caused increased symptoms. Petitioner had trouble getting out of bed the next morning due to pain. The next morning he sought medical treatment and reported the injury to Respondent.

On October 5, 2011, Petitioner had a pre-arranged visit with his primary care physician, Dr. Rhunda El-Khatib, to address anxiety issues. At this visit, Petitioner reported his October 4, 2011 work injury. Dr. El-Khatib treated Petitioner for his anxiety and also ordered an X-ray of Petitioner's lumbar spine and provided him pain medicine. (PX 1at 3-4)

At the request of Respondent, Petitioner reported to Dr. George Dirkers, at Midwest Occupational Medicine. A pain diagram completed by Petitioner the day after the injury indicated he was having pain in his left lower back and left upper hip. (RX 4 at 20) Dr. Dirkers ordered physical therapy at the Work Center in Alton, Illinois. Petitioner was authorized off of work. (PX 6 at12) On November 17, 2011, Dr. Dirkers ordered an MRI of Petitioner's lumbar spine. (PX 6 at 27)

The records from Midwest Occupational Medicine indicate, specifically in the October 13, 2011 and November 3, 2011 office records, that Petitioner was complaining of pain in his low back and pain into his left lower extremity. Petitioner testified that he had pain from his low back into his left lower extremity following the injury and that, as indicated in the records, he reported this to the staff at Midwest Occupational Medicine. When ask why he did not mark leg pain on multiple pain diagrams, Petitioner testified he did not understand how to properly fill out the pain diagrams.

The physical therapy records from the Work Center indicate Petitioner complained of throbbing, burning pain in his left lower back and anterior left hip. At the time of his discharge from the Work Center, Petitioner continued to complain of low back pain with pain radiating into his left lateral thigh and left groin. (PX 6 at 29)

Petitioner underwent an MRI on November 21, 2011 at Excel Imaging. (PX 8) The MRI indicated: "Multilevel facet degenerative changes with accompanying annular L3-4 and more broad based L4-5 disc bulges with superimposed right lateral annular tear at L4-5. There is resulting left greater than right L4-5 and to lesser extent mild to moderate bilateral L3-4 neuroforaminal encroachment without central canal compromise" (PX 8 at 1)

After reviewing the results of the MRI, the company doctor referred Petitioner to Dr. Kaylea Boutwell for epidural steroid injections. (PX 3 at 1) Petitioner first saw Dr. Boutwell on December 14, 2011. Petitioner denied any history of a similar symptoms complex. His complaints on that day were left greater than right low back pain, deep, aching and stabbing in nature, and intermittent radiating sensation down the left leg approximately to the level of the knee. Dr. Boutwell reviewed the November 21, 2011 MRI and concurred with the radiologist's interpretation. Dr. Boutwell referred Petitioner to Apex Physical Therapy to undergo aquatic therapy. Ultimately, Dr. Boutwell performed three epidural steroid injections on Petitioner. Petitioner testified, and the records reflect that he had some relief with the injections but did not have total resolution of his symptoms.

Petitioner then sought medical treatment with Mark Eavenson, DC. Chiropractor Eavenson referred Petitioner to Dr. Matthew Gornet for a neurosurgical evaluation. (PX 5 at 1)

Petitioner first saw Dr. Gornet on January 6, 2012. Dr. Gornet noted a history of injury in which Petitioner was laying-flat on his back changing a part under a truck, when he reached and twisted and felt a pop in his back. (PX 10 at 7-8) Petitioner's pain was mild at first, but progressed throughout the day and became severe that evening. (PX 10 at 8) He reported it to his employer the next day. His main complaints to Dr. Gornet were constant left low back pain, worse with bending, lifting, twisting, pain and numbness in his left leg wrapping around anteriorly to his knee. (PX 10 at 7-8) He reported to Dr. Gornet that the first injection by Dr. Boutwell improved his leg symptoms, but that the symptoms returned with increased activity. (PX 10 at 8) Petitioner denied prior back or leg issues. Id.

Dr. Gornet reviewed the November 21, 2011 MRI films, which he noted to be of moderate to poor quality. It revealed a lateral disc herniation at left foramen at L4-5 with some subtle changes in disc hydration. (PX 10 at 9) Additionally, there was possibly a small protrusion on the foramen on the left at L3-4. Id. Dr. Gornet's diagnosis was disc injury at L4-5 with a lateral disc herniation. (PX 10 at 10) Dr. Gornet recommended that the Petitioner have two more injections from Dr. Boutwell and to continue treatment with Mark Eavenson at Multicare Specialists. (PX 10 at 10 and PX 2 at 2) Petitioner was to continue on light duty. (PX 10 at 10)

Petitioner reported back to Dr. Gornet on February 9, 2012. He indicated that his symptoms were still present, but was clinically improving after the last two injections. Dr. Gornet's plan was for Petitioner to finish his physical therapy at Multicare Specialists and then transition into full duty on February 20, 2012. (PX 10 at 11) The office notes from that date indicate: "[Petitioner] understands he should continue with his light duty work with a ten pound limit until 2/20/12. He is not at maximum medical improvement and if his symptoms increase in severity, then consideration could be given to microdiscectomy through a lateral intertransverse process approach, left side L4-5. We will see him back in two months' time." (PX 2 at 7) In his deposition, Dr. Gornet explained that returning to Petitioner to full duty on February 22, 2012 was a trial and in no way meant he has plateaued or had reached maximum medical improvement. (PX 10 at 12)

On March 9, 2012, Petitioner called Dr. Gornet's office and reported that he had increased symptoms in his left leg and wished to proceed with the recommended surgical procedure. (PX 2 at 10) Petitioner testified, and his phone records show that he had placed his call to Dr. Gornet at 9:50am on March 9, 2012. The testimony at trial showed that Petitioner did not clock into work until 12:00pm on Friday, March 9, 2012. The doctor's office prescribed him steroids. (PX 10 at 14) Dr. Gornet took the Petitioner off of work from March 12, 2012 until he was seen on March 26, 2012. (PX 10 at 15)

On March 26, 2012, Dr. Gornet examined Petitioner and noted a left foraminal disc herniation at L4-5. (PX 2 at 12) Petitioner continued to have left leg pain and weakness. Dr. Gornet recommended a microdiscectomy through a lateral intertransverse process approach. He noted that Petitioner's condition prevented him from working. (PX 2 at 12) Dr. Gornet's office has sought approval of the microdiscectomy and Respondent has denied the treatment. Dr. Gornet testified that he believed delaying Petitioner's treatment may affect his overall outcome. (PX 10 at 16)

Dr. Gornet returned Petitioner to light duty on June 26, 2012. Petitioner testified that Respondent has not accommodated this light duty.

In his evidence deposition, Dr. Gornet testified that he believed the work activity as Petitioner described occurring on or about October 4, 2011, is directly causally connected to Petitioner's disc pathology and subsequent symptoms and requirement for surgical treatment. (PX 10 at 18) Further, he testified, that the causal connection was not broken because of the short period in which Petitioner was returned to work. (Id) Dr. Gornet testified that he would like to perform at least a microdiscectomy, but Petitioner might ultimately require a more invasive procedure. Prior to going to surgery Dr. Gornet would like to perform a repeat MRI and a CT scan. Px10at19.

At the request of the Respondent, Dr. David Lange examined the Petitioner pursuant to Section 12 of the Act. Following the examination, Dr. Lange testified by way of deposition on March 14, 2013. He testified that the November 21, 2011 MRI was of less than ideal diagnostic quality. (RX 1 at 14) Dr. Lange diagnosed Petitioner with axial low back pain and left-legged symptoms which might be radicular in nature. He indicated that the MRI was diagnostic enough to determine that the area of concern in the lumbar spine was the L4-5 level, and that there was no question the lower lumbar region was abnormal. (RX 1 at 34) Dr. Lange determined that Petitioner needed a better workup before he could recommend maximum medical improvement or further treatment. (RX 1 at 34) He testified that the Petitioner can work medium capacity work, occasional lifting up to 50lbs, but with lesser amounts more frequently. He further opined that Petitioner's symptomatology is the result of a traumatic injury. (RX 1 at 23)

Respondent produced a DVD showing Petitioner moving a washing machine on March 24, 2012. The investigator, David N. Coffey, testified that he spent approximately 24 hours total attempting to observe Petitioner and that there is only 5.16 minutes of video total. Petitioner is actually seen on the video for a much shorter period of time. Petitioner testified that he did not injure, or re-injure, his low back while moving the washing machine.

Petitioner testified that his current symptoms are low back pain with pain, numbness, and tingling radiating down his left leg into the left foot and occasional into his right leg. The left leg symptoms are now constant. Petitioner has never had treatment for a low back condition prior to October 4, 2011 and has never experienced leg symptoms from a low back injury prior to that date of accident. Petitioner is aware of the treatment recommended by Dr. Gornet and wishes to proceed.

Petitioner has not received TTD benefits since March 12, 2012.

Based on the foregoing, the Arbitrator makes the following conclusions of law:

1. The Arbitrator finds Petitioner sustained an accidental injury that arose out of and in the course of his employment. This is based on the testimony of Petitioner, Dr. Gornet, and Dr. Lange, as well as all of the medical records presented by both Petitioner and Respondent. Petitioner's testimony regarding the events that occurred on October 4, 2011 were not refuted, and are in fact supported by the medical records.

2. The Arbitrator finds that Petitioner's condition of ill-being - disc injury at L4-5 with a lateral disc herniation - is causally connected to his work injury of October 4, 2011. This finding is based on the testimony of Petitioner, Dr. Gornet, Dr. Lange, and the medical records presented by both Petitioner and Respondent. The Arbitrator notes that the Respondent's IME does not refute the finding of causation as indicated by the Petitioner's treating physician, Dr. Gornet, nor was there any other evidence presented to the contrary.

3. The Arbitrator finds the prospective medical treatment proposed by Dr. Gornet to be reasonable and necessary and causally related to Petitioner's October 4, 2011 work accident. Therefore, the Arbitrator orders Respondent to approve and pay for the proposed, related medical treatment, including an updated MRI and possible surgical intervention to Petitioner's lumbar spine.

14IWCC0324

4. The Arbitrator finds that Respondent shall pay reasonable and necessary medical expenses, pursuant to the medical fee schedule of $765.00 to Dr. Rhunda El-Khatib, as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive an 8(j) credit for any amounts actually paid to medical providers by Respondent's group insurance. Respondent shall hold Petitioner harmless in keeping with Sections 8(j). This finding is based on the testimony of Dr. Gornet.

5. Respondent shall pay Petitioner temporary total disability benefits of $654.58/week for 54 and 2/7 weeks, commencing 3/12/2012 through 3/27/2013, as provided in Section 8(b) of the Act. Petitioner has either been held off of work or put on restricted duty from 3/12/2012 through the date of trial. Respondent has not paid TTD for the periods after 3/12/2012 where Petitioner was held off of work. Further, Respondent has not accommodated or offered to accommodate work within the restrictions recommended by the Dr. Gornet or the IME doctor. The parties stipulated that Petitioner was paid all owed TTD benefits from the date of accident until 3/11/2012; therefore this award covers the period of TTD after 3/11/2012 and is not offset by the amounts paid to Petitioner prior to 3/12/2012.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Bruehl,
Petitioner,

vs. NO. 13 WC 07509

14IWCC0325

State of Illinois
Murray Developmental Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering, the issues of accident and causal connection and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 5, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

14IWCC0325

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAY 0 1 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-04/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

BRUEHL, ROBERT
Employee/Petitioner

Case# **13WC007509**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

14IWCC0325

On 7/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JUL 5 - 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Bruehl
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center
Employer/Respondent

Case # 13 WC 07509

Consolidated cases: ____

14IWCC0325

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Mt. Vernon, on May 8, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ____

FINDINGS

On November 15, 2012, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $39,668.72; the average weekly wage was $762.86.

On the date of accident, Petitioner was 57 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $2,289.00 (enumerated in the conclusions of law), as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 28, 2013
Date

JUL 5 - 2013

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on November 15, 2012. According to the Application, Petitioner was operating a floor stripper machine and sustained injuries to the left arm/shoulder, neck and body as a whole. Respondent disputed liability on the basis of accident and causal relationship. This case was tried as a 19(b) proceeding and Petitioner sought an order for payment of medical bills. Petitioner has another case with Respondent for a low back injury for which Respondent has accepted liability paying both medical and temporary total disability benefits. There was not a demand for payment of temporary total disability benefits in this case because Respondent's making payment of same in the companion case. These two cases were not consolidated for the purposes of trial.

Petitioner worked for Respondent as a housekeeper and, in November, 2012, Petitioner was required to operate both a floor scrubber and a floor buffer for several days. The purpose of the scrubber device was to remove old wax from the floors. The buffer was then used to prepare the floor surface for application of the new wax. Petitioner described the machines as being similar to one another each weighing approximately 100 pounds and both requiring the use of both hands to operate although the buffer was somewhat easier to operate in the scrubber. Petitioner testified that when operating these devices it was necessary to lean against the machine and hold it with both hands close to the chest. While operating the machines, Petitioner testified that they "jerked" virtually all of the time.

Petitioner testified that by the end of the workday on November 15, 2012, he noticed that his left arm was sore and that he was experiencing numbness and tingling down his arm and into his hand. The following day, November 16, 2012, Petitioner completed an "Employee's Notice of Injury" which indicated that while he was buffing the day room and bedrooms, his arm kept falling asleep. Petitioner continued to work; however, on November 19, 2012, he completed another form which indicated that Petitioner was operating the buffer on November 14, 15 and 19 and that on the night of November 15, his left arm ached and kept falling asleep and that it remained in that condition through the weekend up to and including the present.

On November 20, 2012, Petitioner was seen by Roger Young, a Certified Nurse Practitioner. Petitioner informed Young that he had a three week history of left arm pain, parasthesias and numb feelings and that he worked at Murray Center as a custodian and used a lot of vibrating tools, floor scrubbers and pushing devices. Young's assessment was possible carpal tunnel syndrome and cervical neuritis. It was recommended Petitioner have nerve conduction studies performed.

Concurrent with this treatment, Petitioner was also being treated by Dr. Matthew Gornet, an orthopedic surgeon, for a compensable low back injury. When seen by Dr. Gornet on January 3, 2013, Petitioner informed Dr. Gornet that in mid-November he was using a buffer to wax floors and that he subsequently developed neck/shoulder pain and numbness and tingling in his left arm. Dr. Gornet opined that "His symptoms in his neck and shoulder in my opinion are causally connected to his recent work injury of mid-November, 2012."

Dr. Gornet obtained an MRI of Petitioner's cervical spine on January 3, 2013, which revealed degenerative disc disease at multiple levels and foraminal stenosis, in particular, at C5-C6 on the

left side which correlated with Petitioner's symptoms and what appeared to be a central herniation at that level. Dr. Gornet recommended Petitioner have some steroid injections performed. Respondent did not obtain a Section 12 examination of the Petitioner.

At trial, Petitioner testified that he was not working because of the fact that he was still under active medical treatment for his low back. He denied any prior injuries to either the neck or left arm and stated that he still has pain in the neck and shoulder areas as well as tingling in his left arm.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a work-related accident on November 15, 2012, and that his current condition of ill-being in regard to his neck and left upper extremity is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding his work activities that precipitated the symptoms in his neck and left arm was unrebutted.

Dr. Gornet opined that Petitioner's neck and left upper extremity symptoms were related to the work-related accident. There was no expert medical opinion to the contrary.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills associated therewith.

Respondent shall pay reasonable and necessary medical services of $2,289.00 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

Petitioner's Exhibit 1 contains medical bills for services provided to Petitioner; however, the vast majority of the bills contained in said exhibit are for medical services provided to Petitioner as a result of the injury to his low back. The Arbitrator has reviewed the medical bills and has determined that the medical bills for services related to the cervical spine and left upper extremity injury are as follows:

Dr. Gornet	1/3/13	$ 139.00
MRI Partners of Chesterfield	1/3/13	$2,150.00
Total		$2,289.00.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hugh Jones,
Petitioner,
vs.
Ameren,
Respondent,

NO: 10 WC 44346
14IWCC0326

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, causal connection, medical expenses, permanent partial disability, mileage, credit for past award, can the arbitrator amend the onset date on her own motion after the closing of proofs and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 16, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 2 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:4/24/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, HUGH
Employee/Petitioner

Case# **10WC044346**
11WC021550

14IWCC0326

AMEREN
Employer/Respondent

On 1/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1937 TUGGLE SCHIRO & LICHTENBERGER PC
TODD LICNTENBERGER
510 N VERMILION ST
DANVILLE, IL 61832

1337 KNELL & KELLY LLC
PATRICK JENNETTEN
504 FAYETTE ST
PEORIA, IL 61603

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Hugh Jones
Employee/Petitioner

v.

Ameren
Employer/Respondent

Case # **10** WC **44346**

Consolidated cases: **11 WC 21550**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **November 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **mileage**

FINDINGS

On **07/29/10**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,512.00**; the average weekly wage was **$1,068.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$-0-** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$-0-**.

Respondent is entitled to a credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act and any monies paid for lost wages through group disability insurance provided by Respondent pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $712.00/week for 14-2/7 weeks, commencing March 14, 2012, through June 21, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $644.63 to Safeworks Illinois, $536.00 to Lakeland Radiology, $4,460.30 to Provena Covenant, $17,693.20 to Dr. Lawrence Li, $995.00 to Danville Polyclinic, $17,520.00 to Ireland Grove, and $8,107.36 to Pro Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid by Petitioner's group insurance, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8 (j) of the Act.

Respondent shall pay mileage reimbursement for the 1480 miles traveled by Petitioner for physical therapy appointments at the applicable governmental rate for reimbursement as such is an incidental expense as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $640.80/week for 50 weeks, because the injuries sustained caused 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from July 29, 2010 through November 19, 2012, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of Arbitrator

January 13, 2013
Date

ICArbDec p. 2

JAN 16 2013

Hugh Jones v. Ameren, 10 WC 44346

The Arbitrator's Findings of Fact

Chronology of Events pre-arbitration

Petitioner began working for Respondent in 1998 when the company was known as "CIPS." Petitioner sustained an injury on August 14, 2007 when he was working as a lineman for CIPS and he fell off a pole twenty feet in the air. In an effort to keep from falling, Petitioner grabbed onto the pole but was unable to stop the fall and ultimately landed on a fence injuring his right shoulder. He suffered a full-thickness tear of the right rotator cuff and underwent surgery with Dr. Lawrence Li on October 3, 2008. Petitioner continued to treat with Dr. Li post-operatively and during his course of recovery Petitioner mentioned left shoulder pain stemming from a work injury Petitioner had sustained a few years earlier (office note of November 6, 2008). Petitioner had undergone an MRI which showed impingement but the pain was worsening and Petitioner felt he needed it looked at. Treatment to the left shoulder was briefly interrupted after Petitioner fell on ice shortly before Christmas in 2008 and felt a pop in his right shoulder. Petitioner sustained a new tear in the right shoulder which required another surgery on January 28, 2009. Treatment to Petitioner's left shoulder resumed in July of 2009 with injections and physical therapy followed by a left shoulder arthroscopy, biceps tenodesis, rotator cuff repair, subacromial decompression, and debridement of a Type I labral tear on August 19, 2009. Petitioner's left shoulder surgery was followed by physical therapy and a return to work on a restricted duty basis. Therapy progressed slowly and a functional capacity evaluation was performed in February andMarch of 2011. At that time Petitioner had full range of motion and 5/5 supraspinatus and external rotation strength. There was some concern about Petitioner's ability to perform a "top pull rescue" but a way to perform it was found and he was released to regular duty and determined to be at maximum medical improvement on April 8, 2010. (RX 9)

Petitioner resumed his regular work duties for Respondent on April 8, 2010. Petitioner was apprenticing to become a lineman for Respondent.

On August 25, 2010, a meeting was held between representatives for Respondent and Petitioner concerning Petitioner's job options. According to meeting minutes/notes, Petitioner's last performance evaluation was unacceptable. Petitioner was reportedly not progressing or completing the required program and concern was expressed about Petitioner's safety and the safety of those working with him. Petitioner was encouraged to seriously consider bidding on a meter reading position that would be posted in the next day or two. Otherwise, his removal from the apprenticeship program was under serious consideration by the apprenticeship committee and management. Petitioner was noted to be a hard worker but not cut out to be a lineman. (RX 8)

Petitioner filed three workers' compensation claims against Respondent as a result of accidents in 2003 and 2007 (see RX 5). Petitioner settled those claims during August of 2010. The settlement contract Petitioner had signed on August 19, 2010 was approved on August 31, 2010. The parties signed one contract dealing with Petitioner's injuries to his right arm, left arm, and body as a whole. Petitioner was represented by counsel when he signed the contracts. Petitioner settled his claims for the sum of $118,505.51, representing 20 % loss of use of the left arm, 40%

loss of use of the right arm, and 10% loss of use of Petitioner's body (less an overpayment of TTD of $186.24). The contract specifically states:

> It is agreed by and between the parties that the sum of $118,505.51 represents the entire measure of liability owed Petitioner by Respondent as a result of this claim (DOA 12/10/03;08/14/07;12/07/07) and any other claims to date. (RX 13)

Another meeting was held on September 1, 2010 at which time Petitioner was reminded that he was not progressing at a satisfactory rate and that the meter reader position remained open. A discussion ensued at the conclusion of which Petitioner indicated he would give the job serious consideration and thought. (RX 8)

Petitioner presented to Safeworks on September 21, 2010, regarding left shoulder pain complaints which had been present since August 1, 2010. Petitioner indicated he hurt his shoulder pulling on wire to unlock something off a block. Petitioner described constant pain in his left shoulder going down to his elbow and the occasional inability to sleep on his left side due to discomfort. Dr. Fletcher ordered left shoulder x-rays which showed evidence of a prior rotator cuff tear but no definite fracture or dislocation. The doctor's treatment plan was not indicated on the office note; however, a left shoulder gadolinium arthrogram performed on October 11, 2010 showed a full-thickness rotator cuff tear with a gap in the supraspinatus tendon and other post-surgical changes. (PX 1, PX 2, RX 7)

Petitioner presented to Dr. Lawrence Li on October 14, 2010, regarding his left shoulder complaints. Dr. Li had previously operated on Petitioner's left shoulder in August of 2009 when Petitioner required a left rotator cuff repair. According to the doctor's notes, Petitioner had done very well since then but re-injured his left shoulder on August 1, 2010 when he was pulling a "lok block" and felt instant pain. Petitioner initially thought it would improve with time but when it didn't he went to Dr. Fletcher who confirmed a recurrent tear and referred Petitioner to Dr. Li. Dr. Li noted Petitioner was currently working as a meter reader since he could not use his shoulder in a strenuous manner. Dr. Li recommended surgery to the shoulder. (PX 3)

Petitioner gave a recorded statement to Chris Frye on October 27, 2010. Petitioner stated that he had been working for Respondent and its predecessor, Illinois Power, since November of 1998 and was currently a "Meter Reader Groundman." It was awarded to him on September 7, 2010. The adjustor indicated the claimed accident date was August 1, 2010; however, Petitioner explained that he was not "completely sure" about that. He recalled he was working on the Monticello Road project and he was working as an Apprentice Lineman. Petitioner had climbed a pole to help "sag" the wire and he was pulling the wire and finally gave it a "big jerk" and felt immediate pain in his left shoulder. According to Petitioner the pain started out as mild but worsened over time. Petitioner did not believe he said anything to his two co-workers, John and Jason, although he "mighta said something to Jason but [he] can't, you know, cause [he] just, [he] thought it was maybe just a muscle strain and never really said anything about it." Petitioner further explained that he did not notify his supervisor about his shoulder until probably "at least a month later" because he was trying to hold it off. Petitioner explained that he was the type of person who just puts things off till they got so bad and then he would say something if necessary. Petitioner believed it was the middle of September before he said anything and then he told Jim he was going to the doctor to get him to look at his shoulder. "..., that was the first time I really

ever told anybody about it." Petitioner acknowledged he never told Bill Fleming, his supervisor at the time of the alleged accident, about the accident. (RX 1)

During the recorded statement session with Frye Petitioner explained that he had undergone two right shoulder surgeries in 2008 and a left shoulder surgery in August of 2009. Petitioner acknowledged that he had settled those claims. (RX 1)

A "Form 45: Employer's First Report of Injury" was completed by Michelle Feise on October 29, 2010. The accident date was listed as August 4, 2010, the location was "Monticello Road," and the description given was "report shoulder issue on 10/7/10 related back to." (RX 4)

Petitioner signed his Application for Adjustment of Claim in this case on November 8, 2010. A copy of same was presumably mailed to Respondent on November 9, 2010. (RX 5)

Petitioner returned to see Dr. Fletcher at Safeworks on December 6, 2010, reporting that his claim had been denied and that he had sustained a new injury to his left knee since his earlier visit in September. Petitioner's examination of his left shoulder was positive for limited range of motion and a loss of 90 degrees abduction. Dr. Fletcher confirmed the MRI shoulder findings. Dr. Fletcher noted that Petitioner had internal derangement of his left knee but was still dealing with left shoulder issues stemming from Petitioner's August 1, 2010 work accident. Petitioner was told he could continue working his regular job as a meter reader. In addition to recommending treatment to Petitioner's left knee, Dr. Fletcher still recommended a left shoulder repair. (PX 1)

Petitioner next presented to Dr. Li on December 9, 2010 and updated Dr. Li concerning his recent accident while meter reading at a house when he tripped over an anchor for a dog chain and landed on his left side, twisting his left knee and re-aggravating his left shoulder, which already had evidence of a rotator cuff tear. Petitioner reported he was still working but having ongoing knee difficulties while doing so. Dr. Fletcher had referred Petitioner to him. Petitioner's left shoulder showed limited abduction and flexion to about ninety degrees along with pain in the anterior aspect of Petitioner's shoulder. Dr. Li noted Petitioner was still scheduled for shoulder surgery but he also needed an MRI of his left knee. (PX 3) As of December 21, 2010 Dr. Li noted Petitioner's left shoulder was still bothering him significantly and he was scheduled for an IME. (PX 3)

Petitioner was examined by Dr. George A. Paletta Jr. at Respondent's request and pursuant to Section 12 of the Act on January 17, 2011 in Chesterfield, Missouri. In conjunction with the examination, Dr. Paletta reviewed medical records from Dr. Li, Dr. Fletcher, Dr. Milne (an IME), a functional capacity evaluation, and imaging studies. After the examination, Dr. Paletta issued a report which included a discussion of Petitioner's care and treatment both before and after his 2010 left shoulder and left knee accidents. In addition to summarizing Petitioner's medical care outlined above in the Arbitrator's Findings, Dr. Paletta also reviewed an independent medical examination report authored by Dr. Michael Milne on April 19, 2010 in which the doctor commented on Petitioner's left shoulder repair of August 19, 2009, from which Petitioner had done well and, while noted to have some weakness in the supraspinatus and some mild motion limitations, Petitioner was otherwise ready for full duty work as he was at maximum medical improvement and needed no further medical care. (RX 6)

Petitioner provided Dr. Paletta with a history of both his August 4, 2010 work accident to his shoulder and his November 18, 2010, accident to his knee. Petitioner told the doctor he reported the injury but did not seek medical attention because it really didn't get worse for a couple of weeks until he was using ratchet cutters overhead in late August. Dr. Paletta wrote:

> He states that he was using these ratchet cutters up above shoulder level and that he 'had one time where it popped real loud and the shoulder gave out. I think that what done it in.' Once again, he apparently did not report that injury or seek initial medical treatment.
>
> (RX 6, p. 2)

Thereafter, Petitioner had continued pain and difficulty sleeping on his shoulder. Petitioner explained to Dr. Paletta that he then realized he probably could not continue as an apprentice lineman and switched to a meter reader position in early September of 2010.

Petitioner also described the November 18, 2010 accident to Dr. Paletta and advised him that he thought he aggravated his left shoulder at that time as things had been bothering him "a little bit more" since that injury. (RX 6, pp. 2-3)

At the time of the exam with Dr. Paletta, Petitioner described ongoing discomfort in his left shoulder and some difficulty in the elbow position and lying on the affected side. He complained of some pain at night but no radiating pain or associated numbness, tingling, or paresthesias. Petitioner denied the use of any medications for his shoulder. On physical examination of the shoulder, Petitioner displayed some cuff weakness and external rotation strength and supraspinatus strength was 4+/5. Impingement signs were mildly positive. O'Brien sign was equivocal. Dr. Palletta agreed with the diagnosis of a left rotator cuff tear and believed it was causally related to Petitioner's accident of August 10. Dr. Paletta stated "It is impossible to state whether the tear actually occurred in August or whether he had failure of his previous rotator cuff repair with aggravation of symptoms related to persistent underlyng tear." Dr. Paletta further opined that his findings seemed consistent with those of Dr. Milne, thus showing "no material change" in Petitioner's physical examination. Dr. Paletta also believed that the extent of retraction suggested that Petitioner's tear might be more chronic than new. The accident in November of 2010 did not materially impact the left shoulder. All in all, Dr. Paletta found it impossible to state within a reasonable degree of medical certainty whether Petitioner's rotator cuff tear was torn on August 10 or represents a failure of the previous repair. (RX 6)

Petitioner returned to see Dr. Li on November 17, 2011 and reported ongoing symptoms in his left shoulder which were aggravated with reaching and lifting as well as outstretched positions. Surgery was still recommended. (PX 3)

Petitioner underwent left shoulder arthroscopic surgery on March 14, 2012. Dr. Li's post-operative diagnosis was left shoulder massive re-tear of the rotator cuff, impingement syndrome, adhesive capsulitis and grade 2 osteoarthritis of the glenohumeral joint. (PX 5) Surgery was followed by physical therapy. (PX 6) Petitioner's post-operative care was monitored by Dr. Li who returned Petitioner to full duty on June 25, 2012. Petitioner's last visit with Dr. Li was on July 26, 2012 at which time Petitioner reported no complaints but some ongoing weakness in his shoulder. Provocative testing showed 5/5 strength testing and 4/5 external rotation. (PX 3)

Testimony of Dr. Li

(April 30, 2012)

Dr. Li testified he has practiced medicine in central Illinois since 1996. He is board certified with local privileges at multiple hospitals in the central Illinois area. Dr. Li testified he specializes on the shoulders, knees, and hands. Dr. Li testified he does see patients with back pain but does not perform back surgery.

Dr. Li testified Petitioner became a patient on April 17, 2008, for a right rotator cuff tear. Petitioner had a right rotator cuff repair with biceps tenodesis in October 2008. Dr. Li also treated Petitioner for a left shoulder rotator cuff tear in 2009. Petitioner underwent surgery on August 19, 2009, for a biceps tenodesis and rotator cuff repair. Petitioner was released April 8, 2010, for the left shoulder condition when he completed work conditioning and went back to work.

Dr. Li saw Petitioner again on October 14, 2010. Petitioner gave a history of injuring himself when he was on a 40 foot hose hoist pulling a lock block with a really tight lock block. Petitioner tried to pull the lock and felt instant pain in his left shoulder. Petitioner felt instant pain in his left shoulder and saw Dr. Fletcher who obtained an arthrogram. This confirmed Petitioner had a full thickness rotator cuff tear of the left shoulder. Dr. Li saw him shortly thereafter and recommended shoulder surgery.

With regard to restrictions, Dr. Li left those to Dr. Fletcher. Dr. Li did not recall reviewing Dr. Fletcher's notes. Dr. Li would have no reason to disagree with the work restrictions placed upon Petitioner by Dr. Fletcher.

Dr. Li performed left shoulder surgery on March 14, 2012. Dr. Li performed a left shoulder arthroscopy with rotator cuff repair, subacromial decompression, and debridement of scar tissues as well as underlying arthritis.

Dr. Li testified the rotator cuff repair was similar to the one that he performed in 2009; however, the newer rotator cuff repair also showed adhesions and arthritis. Dr. Li noted that there were new bone spurs that had recurred and were also removed, and the arthritis had gotten worse since 2009. Dr. Li testified that is not uncommon.

Dr. Li saw Petitioner as recently as April 19, 2012, for the left shoulder condition. Petitioner was improving and he was going through therapy. Petitioner was scheduled to come back on May 17, 2012, for the left shoulder.

Dr. Li diagnosed Petitioner with rotator cuff tear, adhesive capsulitis, and impingement syndrome, and glenohumeral arthritis. Dr. Li testified the rotator cuff tear was caused by his work injury of August 1, 2010, and the adhesive capsulitis was caused by the wait and time it took for Petitioner to have surgery. Dr. Li noted the impingement syndrome goes along with

rotator cuff tear and is caused by the same problem, and the glenohumeral arthritis was just a natural progression.

Dr. Li testified he anticipated Petitioner being at maximum medical improvement for his left shoulder four to six months post surgery.

On cross-examination Dr. Li testified that his understanding was that Petitioner was pulling some sort of rope with a lock block when he injured his left shoulder. Dr. Li acknowledged Petitioner had immediate pain after that, but did not know how long Petitioner waited for treatment and care. Dr. Li testified it would not surprise him if Petitioner sought no treatment immediately after his claimed injury. Dr. Li testified that Petitioner had his information and was told to come back to see him if he had any problems with his left shoulder. Dr. Li testified that he eventually did come back to see him based upon the re-tear.

Dr. Li could not testify based upon the operative findings whether or not the tear was caused by trauma, as Petitioner's left shoulder surgery occurred more one-and-a-half years after the accident and there was no way to identify trauma during surgery.

Dr. Li testified that if Petitioner continued working following his shoulder injury he would expect him to complain of pain with certain movements.

Testimony of Dr. Paletta

(May 25, 2012)

Dr. Paletta testified he is a board certified orthopedic surgeon that specializes in sports medicine. Dr. Paletta testified that he primarily treats problems with the shoulder, elbow, and knee. Dr. Paletta testified he routinely performs surgeries with 85% to 90% of the procedures performed arthroscopically.

Dr. Paletta had the opportunity to examine Petitioner on behalf of Respondent for purposes of an independent medical evaluation. Petitioner claimed injuries to both his left shoulder and left knee.

Dr. Paletta took a history of Petitioner pulling on a tail of a rope on about 8/4/10 resulting in left shoulder pain. Petitioner told him he was working as an apprentice lineman for Respondent when he was working with refilling some lines with water. Petitioner was pulling on a rope over his right shoulder. As Petitioner was pulling on the tail of the rope he felt immediate pain in the left shoulder. Petitioner did not think he initial injury was that bad, but when it did not get better on its own he sought medical attention. Dr. Paletta had the opportunity to review the MRI and records regarding the left shoulder. Dr. Paletta took a physical examination of the left shoulder which showed positive physical findings consistent with rotator cuff tear. Dr. Paletta found the rotator cuff tear and the need for a revision of the rotator cuff repair to be reasonable. (RX 14)

Dr. Paletta testified that Petitioner's accident in august of 2010 aggravated and/or casued a recurrent tear of Petitioner's rotator cuff in his left shoulder. The mechanism of injury was

appropriate for aggravating and causing a recurrent tear. Dr. Paletta opined that the incident of August 2010 was causally related to Petitioner's shoulder condition. (RX 14, pp. 10-11)

Testimony at Arbitration

Petitioner's Testimony

Petitioner testified that he became an apprentice lineman for Respondent in April of 2010. Petitioner explained that as an apprentice lineman he is training to become a lineman and his duties include putting power poles in the ground and laying underground wires. This was Petitioner's job on August 4, 2010.

Petitioner testified that on August 4, 2010, he was stringing wiring with a foreman and a journeyman. Petitioner was climbing the poles and "sagging" the line. Petitioner testified there was a chute that attached to a pole with a rope and pulley system that helped pull the power wire tight. The wire was pushed through the chute and tightened. Petitioner testified that the journeyman asked him to pull the wire tighter, and while doing so, he jerked on the wire and felt a pop in his left shoulder. Petitioner testified that he told his co-worker, Jason Sparling (a journeyman) that he felt a pop in his left shoulder. Petitioner testified that Sparling did not hold a supervisory position.

Petitioner testified that he had previously torn his rotator cuff in a work accident in 2007. Thereafter, he underwent left shoulder surgery in August of 2009 with Dr. Lawrence Li. Petitioner testified that he was released to return to work in April of 2010, approximately four months before the August 4, 2010 accident. Petitioner testified that he filed a workers' compensation claim on account of the 2007 accident. Petitioner testified that he experienced no problems with his left shoulder from April of 2010 through August of 2010.

Petitioner testified that he did not immediately notify his supervisor about the August 4, 2010 accident because he wanted to see how "it" went and he was settling his other claim.

Petitioner further testified that he continued working as an apprentice lineman from August 4, 2010 through September 7, 2010.

Petitioner testified that he signed the settlement contract stemming from his 2007 left shoulder accident (RX 13) on August 19, 2010. Petitioner testified that he didn't tell anyone about the August 4, 2010 accident when he signed it. Petitioner further testified that he did not review the contract with his attorney before signing it. He acknowledged that someone went over the contract with him but he "didn't listen like [he] should've."

Petitioner testified that he was not keeping up with the other linemen and it was strongly recommended that he change jobs. On September 7, 2010, Petitioner started as a meter reader in Tuscola, Illinois. The meter reader position paid less than Petitioner's prior position.

Petitioner testified that he notified his supervisor, Jim Ippolito, on September 17, 2010 of his August 4, 2010 accident. Petitioner testified that he told Ippolito that he had made an appointment to see Dr. Fletcher because he could not sleep. He wanted to let the company know he would be off work.

Petitioner acknowledged that he gave a recorded statement to Chris Frye indicating that he gave notice to his supervisor. Petitioner saw Dr. Fletcher on September 21, 2010 who subsequently referred him back to Dr. Li. An MRI was ordered on October 11, 2010, and Petitioner saw Dr. Li on October 14, 2010. Dr. Li told Petitioner he needed shoulder surgery and it was scheduled for November of 2010 but then cancelled.

Petitioner continued to work as a meter reader, and could have undergone surgery through his group health insurance; however, he had some problems with bills and elected not to do so. Petitioner returned to see Dr. Li on November 17, 2011. Petitioner testified that during his gap in treatment he was never symptom free. Petitioner ultimately underwent shoulder surgery on March 14, 2012. Before that, however, Petitioner underwent knee surgery as requested by Dr. Li. After his shoulder surgery, Petitioner underwent physical therapy and returned to work on June 21, 2012 as a meter reader.

Petitioner testified that he did not receive any workers' compensation benefits while off work but, instead, received extended sick leave and two weeks of vacation time. Petitioner's bills were submitted through his group health insurance.

Petitioner testified that he continues to work as a meter reader, a job that primarily requires walking. Petitioner also testified that his left shoulder is no longer as strong as it once was. When he goes to pick up a gallon of milk he uses his right hand to assist. Petitioner still feels pain and cannot perform any overhead work,

On cross-examination Petitioner testified that he was intimidated as an apprentice and didn't want to tell anybody about his accident. Jason was the only person Petitioner told about the accident. Petitioner also testified that he had meetings in August and September of 2010 concerning his job performance and during those times he never told anyone he was having problems performing his job due to a shoulder problem. Petitioner testified that he told Ippolito he wanted to go to the doctor before he filled out an accident report. Petitioner agreed that from June 1, 2010 through September 7, 2010 he never told his supervisor, Bill Fleming, that he had any problems with his shoulder. Petitioner acknowledged that he never required any restrictions during this time period and was able to perform all of his job duties as an apprentice lineman. Petitioner agreed that he left his work as an apprentice lineman due to performance issues and not due to any problems with his shoulder.

Petitioner acknowledged on cross-examination that he was working with co-workers when he claimed he was injured on August 4, 2010. Petitioner agreed he gave a recorded statement to the adjustor and agreed that his memory was better when he gave his recorded statement in 2010 than it was when testifying. Petitioner agreed that he was working with John Hyde and Jason Sparling when he claimed he was injured and admited in a recorded statement that he did not tell John Hyde and Jason Sparling about his claimed accident.

Petitioner agreed that after his claimed accident on August 4, 2010 he continued to work as an apprentice lineman for about another month without any problems.

Petitioner acknowledged on cross-examination that he was familiar with reporting requirements at his job as an apprentice lineman and was aware that he had to report any work injury as an apprentice lineman to his supervisor.

With regard to Petitioner's treatment and care, Petitioner acknowledged on cross-examination that he chose this medical treatment and care for his left shoulder. Petitioner specifically sought out medical treatment with Dr. Fletcher. Furthermore, Petitioner specifically sought out medical treatment with Dr. Li. Petitioner acknowledged that he had similar treatment options, including orthopedic care with potential surgeries much closer to home than Dr. Fletcher or Dr. Li. Petitioner acknowledged that those physicians were his choice and that he chose to go additional distances for his treatment and care.

Petitioner acknowledged on cross-examination that he was not exactly sure of the date of his accident. Petitioner was uncertain as to whether or not his injury occurred on the last day of the Monticello Road Project. Petitioner acknowledged that the accident could have happened on a different date as he was not 100% certain as to the exact date his accident occurred. Petitioner was quite certain, however, that Jason Sparling and John Hyde were present on the date of the accident.

Petitioner was called as a witness by Respondent in its case-in-chief. Petitioner acknowledged that he did fill out paperwork for Dr. Fletcher on September 21, 2010 requesting that Dr. Fletcher's office submit bills to Petitioner's group health insurance carrier. Petitioner testified that he did this because he didn't want to report his injury as work-related.

Testimony of Bill Fleming

Bill Fleming testified he has worked for Respondent as a line supervisor for quite some time and that Petitioner was an apprentice lineman under his supervision.

Fleming further testified that as an apprentice lineman, employees were required to perform work involving electrical lines. This included running electrical lines in the ground as well as running electrical lines along poles and running wire from pole to pole. Fleming testified that an apprentice lineman position involves heavy use of both shoulders and can involve pulling on rope, use of heavy equipment, pole climbing, and overall heavy use of both arms.

Fleming acknowledged he had Petitioner working for him in 2010 as an apprentice lineman. Fleming had Petitioner working for him on a project known as the Monticello Road Project that ran from June 1, 2010 through August 4, 2010. Fleming testified that Petitioner never reported an accident to him as occurring on the Monticello Road Project. Fleming testified Petitioner never reported pain to him in performing job duties during the Monticello Road Project. Petitioner never reported any shoulder pain or any pain at all while working for Fleming as an apprentice lineman.

Fleming testified that Petitioner stopped working for him as an apprentice lineman due to performance issues. Bill Fleming testified that Petitioner had problems working as an apprentice

lineman. Fleming testified there were meetings set up with Petitioner regarding his job performance, where it was suggested Petitioner take a different job such as a meter reader position. Fleming discussed the job change from apprentice lineman to meter reader with Petitioner. Various persons were present during these meetings and discussions and these were introduced as Respondent's Exhibit No. 8. During these meetings, Petitioner never mentioned shoulder pain or shoulder problems as a reason for leaving as an apprentice lineman.

Fleming testified that Petitioner never reported a work accident to him. Fleming testified that his employees, including Petitioner, in the capacity of apprentice lineman, were required to report accidents to him. Fleming testified that if Petitioner had reported an accident to him he would have informed the proper sources at Ameren including filling out an accident report. Fleming testified that Petitioner never reported a work accident and he never filled out an accident report for Hugh Jones.

Fleming testified he first learned of Petitioner's claimed accident when an e-mail was sent by Jim Ippolito on October 20, 2010. Otherwise, he was unaware of Petitioner's claimed accident until that date.

Fleming testified that he reviewed the daily job notes for the Monticello Road Project prior to testifying. Fleming testified that there was only one day that Jason Sparling was working on the job and that was on July 29, 2010. Fleming testified that he was present on that day in addition to Petitioner, Jason Sparling, as well as John Hyde. Fleming testified on cross-examination that he was certain from reviewing the daily log jobs that the only day Jason Sparling would have been working on the Monticello Road Project would have been July 29, 2010.

Testimony of Jim Ippolito

Jim Ippolito testified he has been a distribution design engineer for Respondent since 2003. He has been Petitioner's supervisor since September 8, 2010 when Petitioner came to work for him as a meter reader.

Ippolito testified that Petitioner never informed him of any problems with his left shoulder when he came to work for him in September of 2010. Ippolito did not remember Petitioner reporting any injury to him as occurring with Respondent on the line job prior to October of 2010. Ippolito testified if Petitioner had reported an accident to him before October of 2010 he would have informed other persons at Respondent right away.

Ippolito testified he always diligently reports employee accidents and injuries Ippolito testified hypothetically that if Petitioner had come to him in September of 2010 and reported a shoulder injury to him he would have immediately reported it to his superiors at Ameren.

Ippolito testified that he was uncertain of the exact date that Petitioner informed him of his claimed August 2010 work accident. However, Ippolito testified he reviewed an e-mail from October 20, 2010 and agreed that Petitioner would have initially told him about his claimed shoulder accident within a few days of that date. Ippolito testified that he offered an e-mail to his superiors at Respondent regarding the work accident on October 20, 2010, and it would have

been in and around that time period that Petitioner informed him of his claimed shoulder accident/injury while working as an apprentice lineman.

On cross-examination Ippolito acknowledged that when Petitioner saw Dr. Fletcher in September of 2010 he would have to ask for time off from me. However, on re-direct examination, Ipppolito explained that when Petitioner requested the time off, he said nothing about a work accident.

Testimony of Julie Munsch

Julie Munsch testified she is a claims adjuster working for CCMI. Munsch has worked as a workers' compensation claim adjustor for CCMI for some time. Munsch has adjusted claims for CCMI for a number of years and adjusts workers' compensation claims only for Respondent. Munsch does not do work for any other companies other than Ameren in terms of adjusting workers' compensation claims.

Munsch testified that she handled Petitioner's claims while working with Respondent prior to 2010. Julie Munsch testified these claims included injuries to both the right and left shoulders. Julie Munsch agreed to settle those claims with Petitioner and on behalf of Respondent in August and September of 2010. As of the time that Munsch agreed to settle Petitioner's bilateral shoulder claim, she was unaware of any other claims for Petitioner involving his left shoulder.

Munsch testified she did not become aware of Petitioner claiming an injury to the left shoulder in 2010 until after she received approved lump sum settlement contracts for his old claims. Julie Munsch testified she learned of these when she received paperwork from Dr. Fletcher in October of 2010.

Munsch testified that if she were aware of Petitioner's claimed August 4, 2010 accident she never would have agreed to settle the earlier claims with Petitioner. Munsch testified that since Petitioner had an injury to the same part of the body as one of the earlier accidents, specifically a new accident to the left shoulder with Petitioner having a pending potential claim to the left shoulder, she never would have agreed to resolve the earlier claims. Munsch testified that it is Respondent's policy not to settle a claim when a claimant has new claims that are still pending.

Munsch testified that Respondent has been materially affected by Petitioner settling his earlier claim at the same time he had an accident involving a body part that was reflected in those settlement contracts. Specifically, Petitioner had a previous left shoulder claim with a rotator cuff surgery that was similar to the claimed August of 2010 accident. Because of that, Respondent never would have agreed to settle the earlier case if they had been aware of the August 2010 claimed accident.

Munsch testified that Respondent was prejudiced by Petitioner's late reporting of his alleged accident. Munsch explained that she was aware of the new case law ruling that permanency for shoulder injuries should be measured as a loss of a man as a whole, rather than a loss of a percentage of an arm. Petitioner's old claim was settled as a left shoulder/arm claim. With the new standards of man as a whole, Munsch was aware that there is no credit for man as a

whole. Munsch testified that Respondent has been prejudiced in that it may not receive credit for the older claim should Petitioner prevail.

Conclusions of Law

1. Petitioner was credible and his reason(s) for not mentioning the accident earlier than he did were believable.

2. Petitioner sustained an accident on July 29, 2012, that arose out of and in the course of his employment with Respondent. Petitioner testified he hurt himself on August 4, 2012, but was admittedly unsure of the date. Petitioner seemed sure that he was working with Jason Sparling and John Hyde at the time of the accident. Neither of these gentlemen testified to refute the actual events. The initial medical records from Dr. Fletcher and Dr. Li reflect a date of injury of August 1, 2010. The testimony of Bill Fleming suggested that if an injury occurred it would have been on July 29, 2010, as that was the only day Petitioner worked with Jason Sparling on the Monticello Project. Petitioner testified he recalled Jason Sparling working at the Monticello Project more than just one day. Respondent did not offer any evidence to suggest the accident had not occurred, only evidence that the accident did not occur on August 4, 2010. Given the testimony and documentary evidence the Arbitrator finds that an accident did occur as described by Petitioner. The issue seems to be when the accident occurred and not whether or not it actually occurred. Given the testimony of Bill Fleming and the uncertainty of Petitioner, the Arbitrator finds the accident occurred on July 29, 2010. Moreover, the Arbitrator, on her own motion, amends the onset date from August 4, 2010 to July 29, 2010, in order to conform with the evidence and proof.

3. Petitioner did give notice within the statutory time period. It has previously been established that the accident occurred on July 29, 2010. Petitioner claims he gave notice to Jim Ippolito on September 17, 2010, which was 50 days after the accident. Jim Ippolito claimed to have received notice sometime in October 2010 via an email. The Form 45 indicates the injury was reported to the employer on October 7, 2010. Chris Frye of Corporate Claims Management, the workers' compensation administrator for Respondent, took a recorded statement from Petitioner on October 27, 2010. Section 6(c) of the Act requires notice be given to the employer within 45 days of the accident. However, Section 8(j) of the Act extends the period of notice of accident. Section 8(j) provides:

   "In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. *In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments.* This paragraph does not apply to payments

made under any group plan which would have been payable irrespective of an accidental injury under this Act."

Petitioner testified his group health insurance paid the medical bills and that he received some group disability benefits while he was off work from March 14, 2012, through June 21, 2012. Moreover, on the Request for Hearing form, the parties agreed to Respondent's Section 8(j) credit claim that it paid Petitioner's medical bills and compensated him for time missed from work. The Arbitrator finds that Section 8(j) of the Act extended the Section 6(c) notice period well past any of the notice dates evidenced by testimony or documentation, as referred to above. The Commission had occasion to consider a similar fact pattern in Rudd v. Harris Corporation, 02 WC 28594, 11 IWCC 0045, 2011 WL 507010 (January 13, 2011), and reached the same legal conclusion.

While Petitioner's silence at the time of the settlement does give some pause for thought, the issue of any alleged prejudice to Respondent appears to be moot given the language of Section 8(j). Additionally, Petitioner's silence regarding any left shoulder complaints after the accident could be attributable to his stoic nature and/or job situation at that time.

4. Petitioner's current condition of ill-being is causally connected to the work accident of July 29, 2010. This is based upon the expert testimony of both Dr. Lawrence Li and Dr. George Paletta, Jr. The Arbitrator also notes the causation opinions of Dr. Fletcher periodically expressed in his office notes. Petitioner does have a companion claim (11 WC 21550) in which Petitioner fell over a dog anchor/chain while engaged in meter reading duties on November 18, 2010. According to some of the medical records and Petitioner's recorded statement of December 14, 2010 (RX 2) Petitioner originally believed he may have aggravated his left shoulder in that accident. Any aggravation was a temporary one and did not break the chain of causation between the earlier 2010 accident and Petitioner's shoulder condition.

5. Petitioner is awarded reasonable and necessary medical bills totaling $49,956.49, subject to the fee schedule. Pursuant to a stipulation between the parties, Respondent is entitled to credit under Section 8(j) of the Act for any monies paid for medical bills through group health insurance provided by Respondent to Petitioner. Petitioner is also awarded reimbursement for 1480 miles of travel to and from physical therapy appointments at the applicable governmental rate of reimbursement. Section 8(a) of the Act requires the employer to pay for physical rehabilitation of the employee, including all expenses incidental thereto. The Arbitrator finds Petitioner's travel to and from the physical therapy appointments to be such an incidental expense.

6. Petitioner is awarded temporary total disability benefits beginning March 14, 2012 (the date of surgery) through June 21, 2012 (the day he was released to return to full duty by Dr. Lawrence Li), a period of 14 2/7 weeks. Pursuant to a stipulation between the parties, Respondent is entitled to credit under Section 8(j) of the Act for any monies paid for lost wages through group disability insurance provided by Respondent to Petitioner.

7. Petitioner's testimony regarding the nature and extent of his condition is consistent with the medical records, including those of Dr. Milne. Petitioner underwent surgery and was released to return to work with no restrictions. He returned to full duty work as a meter

reader. Petitioner's inability to return to work as an apprentice lineman (the job he held at the time of the accident) is unrelated to his left shoulder injury. Petitioner testified to experiencing pain and loss of strength. When examined by Dr. Milne on April 19, 2010, Petitioner complained of shoulder weakness. There was some issue as to Petitioner's ability to perform a "pole rescue" due to restrictions of his shoulders as evidenced by an FCE. Nevertheless, Dr. Milne believed Petitioner could return to full duty. Dr. Paletta did not re-examine Petitioner after his surgery and therefore rendered no opinions regarding permanency post-surgery. Petitioner's examination on July 26, 2012 indicated objective findings very similar to those of Dr. Milne back in 2010. Petitioner has sustained permanent partial disability of 10% loss of man as a whole.

8. Respondent is not entitled to credit for a past settlement wherein it paid Petitioner 20% loss of use of the left arm. Section 8(e)17 of the Act does not allow for a deduction of prior awards regarding a subsequent injury which results in an award of benefits pursuant to Section 8(d)2 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hugh Jones,
Petitioner,
vs.
Ameren,
Respondent,

NO: 11 WC 21550
14IWCC0327

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, temporary total disability, mileage, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 16, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $39,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 2 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:4/24/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, HUGH
Employee/Petitioner

Case# **11WC021550**

10WC044346

14IWCC0327

AMEREN
Employer/Respondent

On 1/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1937 TUGGLE SCHIRO & LICHTENBERGER PC
TODD LICHTENBERGER
510 N VERMILION ST
DANVILLE, IL 61832

1337 KNELL & KELLY LLC
PATRICK JENNETTEN
504 FAYETTE ST
PEORIA, IL 61603

14IWCC0327

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Hugh Jones
Employee/Petitioner

v.

Ameren
Employer/Respondent

Case # 11 WC 21550

Consolidated cases: 10WC44346

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana, IL**, on **November 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Payment for medical mileage**

FINDINGS

On **11/18/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$28,832.00**; the average weekly wage was **$1,030.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act and any monies paid for lost wages through group disability insurance provided by Respondent pursuant to Section 8(j) of the Act.

ORDER

Respondent shall be given a credit for medical benefits that have been paid by Petitioner's group insurance, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8 (j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $686.67/week for 8-6/7 weeks, commencing January 11, 2012, through March 13, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,077.69 to Safeworks Illinois, $9,705.27 to Dr. Lawrence Li, $418.00 to Danville Polyclinic, $10,338.00 to Ireland Grove, and $2,992.00 to Pro Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay $266.40 for mileage reimbursement for the 480 miles traveled by Petitioner for physical therapy appointments as such is an incidental expense as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $618.00/week for 53.75 weeks, because the injuries sustained caused 25% loss of use of the left leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from November 18, 2010 through November 19, 2012, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of Arbitrator

January 13, 2013
Date

JAN 16 2013

After considering all the evidence, the Arbitrator finds as follows:

Petitioner testified that on November 18, 2010, he was working as a meter reader for Respondent, a company which provides electricity service to homes and businesses. Petitioner testified he was reading meters in Arcola, Illinois, and as he was walking from one yard to another he tripped over a dog chain anchor which was hidden under fallen leaves. Petitioner testified he fell to the ground, landing on his left side, and was eventually able to get up under his own power. Petitioner testified there was pain in the left knee. Petitioner testified he had no prior injuries to his left knee and had no problems with the left knee at any time prior to this accident. Petitioner gave a recorded statement to Julie Munsch of Corporate Claims Management on December 14, 2010, and provided essentially the same information as was provided at trial (RX. 2).

Petitioner saw Dr. David Fletcher of Safeworks Illinois on December 6, 2010 (PX. 1). Petitioner described a stabbing pain in the left knee and indicated the pain was interfering with his sleep (PX. 1). Dr. Fletcher assessed internal derangement of the left knee and referred Petitioner to Dr. Lawrence Li, an orthopedic surgeon (PX. 1). Petitioner saw Dr. Fletcher again on December 9, 2010, and was told he could continue working as a meter reading pending further treatment with Dr. Li (PX. 1).

Petitioner saw Dr. Lawrence Li on December 9, 2010, and a MRI of the left knee was ordered (PX. 2). The MRI of the left knee was done at Dr. Li's office on December 22, 2010, and revealed chronic degenerative tearing of the medial meniscus and maceration involving the posterior horn and body (PX. 2). Petitioner saw Dr. Li again on December 27, 2010, at which time Dr. Li noted the arthritis and underlying degenerative tearing, and opined the accident had made Petitioner's condition significantly worse (PX. 2). Dr. Li gave Petitioner a corticosteroid injection that day which was tolerated well (PX. 2).

Petitioner presented at the offices of Dr. George Paletta, Jr. on January 17, 2011, for an independent medical exam scheduled by Respondent (RX. 14, Exb. 3).

Petitioner testified he continued working as a meter reading for Respondent. Petitioner testified he continued to have problems with the left knee but did not feel the need to complain to his supervisor about the problems. Petitioner testified the knee problems persisted through 2011. Petitioner testified he had problems in the left knee throughout 2011. Petitioner testified he eventually went back to Dr. Li for further treatment.

Petitioner saw Dr. Li again on December 22, 2011, at which time he reported chronic pain which was now worse than the shoulder pain he was experiencing from a different injury (PX. 2). Dr. Li recommended left arthroscopic knee surgery (PX. 2).

Petitioner presented at Danville Polyclinic on January 4, 2012, and January 5, 2012, for pre-operative examinations (PX. 3).

On January 11, 2012, Dr. Li performed surgery on Petitioner's left knee (PX. 2). The procedure was performed at Ireland Grove Surgery Center (PX. 4). The procedure performed by Dr. Li included a left knee arthroscopy with partial medial and lateral meniscectomy, and abrasion chondroplasty of the medial femoral condyle, patella and femoral trochlea and removal of loose bodies (PX. 2; PX. 4). Petitioner saw Dr. Li in follow up on January 19, 2012, at which time Dr. Li prescribed a physical therapy regimen (PX. 2).

Petitioner presented to Professional Physical Therapy on January 23, 2012, for an initial physical therapy evaluation (PX. 5). Petitioner continued physical therapy through February 15, 2012 (PX. 5).

Petitioner saw Dr. Li on February 16, 2012, at which time he noted Petitioner was doing well (PX. 2). Dr. Li advised Petitioner he could go forward with left shoulder surgery (incorrectly noted as right shoulder surgery in the doctor's office note) (PX. 2). Dr. Li testified the left shoulder surgery was performed on March 14, 2012 (PX.11, p. 12).

Dr. Li testified he saw Petitioner in follow up for both the left knee condition and the left shoulder condition on March 22, 2012, and April 19, 2012 (PX. 11, p. 29). Dr. Li testified that Petitioner was released from care regarding the left knee injury approximately three months after the surgery (PX. 11, p. 30).

Petitioner testified he had a good result from the surgery. Petitioner testified he has been working as a meter reader since June 2012 without significant problem. Petitioner testified most of the pain is gone but he has discomfort on occasion. Petitioner testified the left knee becomes painful when walking on uneven surfaces. Petitioner testified he used to run for exercise but can no longer do that on a sustained basis. Petitioner testified he is not taking any prescription medication for residual symptoms but does use over-the-counter pain medications.

Dr. Lawrence Li was deposed on April 30, 2012 (PX. 11). Dr. Li testified that when he saw Petitioner on December 22, 2011, his left knee pain had gotten worse and he continued to have a positive McMurray's test (PX. 14, pp. 23-24). Dr. Li testified that when he performed the arthroscopy on January 11, 2012, he found tears of the medial and lateral meniscus, grade 3 changes on the medial femoral condyle, grade 4 changes to the patella, and loose bodies in the knee (PX. 11, p. 24). Dr. Li testified those condition were caused by a combination of factors (PX. 11, p. 26). Dr. Li testified the chondral changes, namely the arthritis and loose bodies were degenerative in nature (PX. 11, pp. 26-27). Dr. Li testified the Petitioner probably had a pre-existing medial meniscus tear that was made larger and symptomatic by the work related accident (PX. 11, p. 27). Dr. Li testified the lateral meniscus tear was degenerative in nature (PX. 11, p. 27). Dr. Li testified all the conditions were pre-existing and that some or all of them were made worse by the injury (PX. 11, p. 27). Dr. Li testified the most likely cause for Petitioner's need for treatment, including surgery, was the medial meniscus tear (PX. 11, p. 27). Dr. Li testified the pre-existing tear in the meniscus made Petitioner more susceptible to further tearing (PX. 11, p. 40). Dr. Li testified he relied upon the fact that Petitioner was asymptomatic prior to the injury and symptomatic afterwards (PX. 11, p. 39). Dr. Li testified he did not believe the accident resulted in a temporary increase in symptoms since the symptoms had not resolved on their own (PX. 11, p. 27).

Dr. George Paletta, Jr. was deposed on May 25, 2012 (RX. 14). Dr. Paletta testified he saw Petitioner for an independent medical examination (RX. 14, p. 5). The report prepared by Dr. Paletta indicates his examination of Petitioner occurred on January 17, 2011 (RX. 14, Exb. 3). Dr. Paletta took a history of injury to Petitioner's left knee when he was reading a meter and tripped over a dog leash causing him to twist and fall injuring his left knee. Dr. Paletta reviewed a copy of the left knee MRI report. He testified he could reasonably rely upon the report to testify and give an opinion. The report showed a chronic appearing tear of the medial meniscus involving the posterior horn and medial body. There was also evidence of degenerative disease.

Dr. Paletta testified Petitioner was suffering from chronic degenerative joint disease of the left knee, involving mainly the medial compartment and patellafemoral compartment, with associated chronic degenerative meniscus tear (RX. 14, p. 14). Dr. Paletta testified there was no causal connection between those conditions and the work accident of November 18, 2010 (RX. 14, p. 14). Dr. Paletta testified that Petitioner had some symptoms in the left knee related to the accident, but those symptoms had been appropriately treated by Dr. Li, prior to January 17, 2011 (PX. 14, p. 15). Dr. Paletta testified on direct examination that Petitioner was basically asymptomatic when Dr. Paletta saw him on January 17, 2011 (RX. 14, p. 15). Dr. Paletta testified that the corticosteroid injection administered by Dr. Li on December 27, 2010, resulted in complete relief of Petitioner's symptoms (RX. 14, p. 17).

On cross-examination, Dr. Paletta testified Petitioner reported to him that the injection was wearing off (RX. 14, p. 19; RX. 14, Exb. 3, p. 3). Dr. Paletta testified that after the injection wore off, some of the symptoms experienced immediately after the trip and fall had completely resolved and some of the symptoms were starting to recur (RX. 14, p. 21).

Petitioner offered into evidence the following medical bills:

Safeworks Illinois (12/06/10 – 12/09/10) - $1,077.69 (PX. 6);
Dr. Lawrence Li (12/09/10 – 02/16/12) - $9,705.27 (PX. 7);
Danville Polyclinic (01/04/12 – 01/05/12) - $418.00 (PX. 8);
Ireland Grove (01/11/12) - $10,338.00 (PX. 9); and
Professional Physical Therapy (01/23/12 – 02/15/12) - $2,992.00 (PX. 10).

The Arbitrator concludes:

1. Petitioner's current condition of ill-being is causally connected to the work accident of November 18, 2010. This conclusion is based upon a chain of events and the credible testimony of Dr. Li. While both doctors were credible in their testimony, the testimony of Dr. Lawrence Li is more consistent with the evidence in its entirety. Both doctors agree that Petitioner was experiencing symptoms in the left knee, caused by the accident. Both doctors agree there was significant pre-existing degeneration and arthritis in Petitioner's left knee. Petitioner testified his left knee was asymptomatic at all times prior to the accident. That testimony is unrebutted. Dr. Paletta is of the opinion that the injury was temporary and had resolved by the time he saw Petitioner on January 17, 2011. Dr. Paletta initially testified the corticosteroid injection administered by Dr. Li on December 27, 2010, had completely resolved Petitioner's symptoms and brought him back to baseline. However, upon further questioning, Dr. Paletta testified only some of Petitioner's symptoms had resolved and others were recurring as of January 17, 2011. It should be noted that the examination done by Dr. Paletta occurred only 21 days after Dr. Li administered the injection. Given such a short time period, the recurring symptoms suggest the injection only provided temporary relief to a more significant injury. Dr. Li testified the accident caused a worsening of Petitioner's pre-existing torn meniscus which required surgery. Petitioner testified he was having trouble with the left knee throughout 2011 prompting him to return to Dr. Li for more treatment. Dr. Li testified that when he saw Petitioner on December 22, 2011, his left knee condition had not improved compared to the examination in December 2010. Petitioner testified he had a good result from the surgery and that most of the pain was gone from the left knee. The overall evidence of the file does not support a finding that Petitioner's condition had resolved by January 17, 2011. The evidence supports a finding that Petitioner's condition continued throughout 2011 and only resolved after having surgery performed.

2. Petitioner is awarded reasonable and necessary medical bills totaling $24,530.96, subject to the fee schedule. Pursuant to a stipulation between the parties, Respondent is entitled to credit under Section 8(j) of the Act for any monies paid for medical bills through group health insurance provided by Respondent to Petitioner. Petitioner is also awarded reimbursement in the amount of $266.40 (480 miles @ 55.5¢ per mile) for mileage driven to and from physical therapy appointments. Section 8(a) of the Act requires the employer to pay for physical rehabilitation of the employee, including all expenses incidental thereto. The Arbitrator finds Petitioner's travel to and from the physical therapy appointments to be such an incidental expense.

3. Petitioner is awarded temporary total disability benefits beginning January 11, 2012, through March 13, 2012, a period of 8 6/7 weeks. It appears from the records and testimony that Petitioner was off work for the left knee injury up to the time he had a left shoulder surgery on March 14, 2012. Thereafter, any time missed from work was primarily due to treatment regarding the left shoulder condition which is not a claimed injury in this case. Pursuant to a stipulation between the parties, Respondent is entitled to credit under Section 8(j) of the Act for any monies paid for lost wages through group disability insurance provided by Respondent to Petitioner.

4. Petitioner was credible. His testimony regarding the nature and extent of his condition is consistent with the medical records. Based upon the medical evidence and Petitioner's credible testimony, Petitioner has sustained permanent partial disability of 25% loss of use of the left leg. Petitioner sometimes experiences symptoms in the left leg that interferes with his ability to sleep. Petitioner is able to control those symptoms with over-the-counter medications. Petitioner is somewhat limited in his use of the left leg as it becomes symptomatic when he walks on uneven ground at work. Petitioner testified his knee slows down his pace at work. Petitioner no longer jogs.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Williams,

Petitioner,

vs.

NO: 11 WC 19938

14IWCC0328

Secretary of State,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical expenses, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0328

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond or summons for State of Illinois cases.

DATED: MAY 0 2 2014

MB/mam
O:4/24/14
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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

WILLIAMS, JEFF
Employee/Petitioner

Case# **11WC019938**

14IWCC0328

SECRETARY OF STATE
Employer/Respondent

On 3/6/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST
8 MAIN
SPRINGFIELD, IL 62794-9208

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAR 6 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jeff Williams
Employee/Petitioner

v.

Secretary of State
Employer/Respondent

Case # **11** WC **19938**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **12/19/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **5/11/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$52,070.00**; the average weekly wage was **$1,001.35**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

Respondent is entitled to a credit of **$All Medical Paid through group** under Section 8(j) of the Act.

ORDER

Claim Denied. See attached decision.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edward Lee — Signature of Arbitrator

3/4/13 — Date

ICArbDec19(b)

MAR 6 - 2013

Jeff Williams v. Secretary of State

IWCC No. 11 WC 19938

The Arbitrator finds the following facts:

On May 11, 2011, Petitioner was employed by the Illinois Secretary of State as a public service representative in Mt. Vernon, Illinois. Petitioner's application for adjustment of claim indicates that he sustained repetitive trauma injuries to both his right and left hands and arms on that date.

Petitioner testified that, when he was hired in 1984, his duties involved significantly more active upper extremity use such, as handwriting and fine manipulation. Petitioner testified that the facility's equipment modernized significantly between 2000 and 2003, making several aspects of his job easier and less hand intensive. Petitioner indicated that he previously handwrote each applicant's information and confirmed their information via telephone before rewriting or typing out the relevant documentation. Petitioner now enters only an applicant's driver's license number to pull up their records via the computer system. In the case of new applicants without a prior record in the Secretary of State system, Petitioner enters the relevant information on a form in his computer. Petitioner testified that license photography was initially done with a camera, a card, and a laminator, but is now done with three clicks of a mouse.

Several of the activities described by Petitioner involve handwriting or mouse use. Petitioner testified that he is right handed and does not believe that handwriting or using a mouse contributed to the development of the left sided symptoms for which he is now seeking treatment. Petitioner testified that his typing generally consists of filling out forms, and does not entail the drafting of paragraphs or narrative reports. Petitioner testified that he does not use hand tools or vibratory tools during the course of his duties. Petitioner testified that he sweeps the motorcycle course, but it is not his responsibility to keep the driver services facility clean. Petitioner's testimony was largely corroborated by James Nelson, one of Petitioner's former supervisors; however, Mr. Nelson did clarify that Petitioner rarely sweeps the motorcycle course.

Petitioner's upper extremity treatment did not begin in 2011; it began in 2002. Petitioner first reported upper extremity complaints to Dr. James Chow on May 7, 2002. (Rx 7) On that date, Petitioner was diagnosed with lateral epicondylitis of the right elbow, bilateral thoracic outlet syndrome, and possible carpal tunnel syndrome. (Id) Seven days later, a nerve conduction test revealed bilateral carpal tunnel syndrome. (Id) After an unsuccessful course of conservative treatment, Petitioner underwent a right side endoscopic carpal tunnel release on July 10, 2002. (Id) Petitioner continued to treat with Dr. Chow post-surgically and initially reported significant resolution of his symptoms. (Id) In September of 2002, Petitioner was diagnosed with DeQuervian's disease and fitted for a right thumb splint. (Id) When Petitioner's DeQuervain's splint failed to resolve his symptoms, he was given an abductor splint for his right thumb. (Id) Petitioner was referred to Dr. Joon Ahn for his right hand, thumb, middle finger, and elbow complaints. (Id) On January 24, 2003, Dr. Ahn diagnosed bilateral basal joint synovitis, possible early arthritic changes, middle finger PIP joint stiffness and right lateral epicondylitis. (Id) Petitioner's basal joint was injected with steroids and he continued conservative treatment for his carpal tunnel

syndrome. (Id) Petitioner was seen by Dr. Ahn on March 26, 2003, at which time Dr. Ahn recommended a left sided carpal tunnel release without surgery for basal joint arthritis. (Id) Dr. Ahn noted that there were no significant arthritic changes seen on Petitioner's x-rays, but he did feel that Petitioner had some degree of chondral arthritis changes. (Id)

Petitioner neither sought nor received any upper extremity treatment between March 26, 2003, and April 27, 2004. On April 27, 2004 a report was issued by Dr. James Emmanuel who diagnosed left carpal tunnel syndrome and possible right recurrent carpal tunnel syndrome. (Rx 9) Dr. Emanuel described Petitioner's job activities primarily typing, writing, and doing license plate and title work. (Id) Based on this description Dr. Emanuel felt that Petitioner's carpal tunnel syndrome was related to his work. (Id) Dr. Emanuel felt that Petitioner's neck, shoulder, and elbow complaints were not work related, and could instead to be linked with his hobby of working with horses. (Id)

Petitioner reported to Dr. David Strege on May 12, 2004 with complaints of pain over the right radial aspect of the forearm radiating into his right shoulder. (Rx 8) Electrodiagnostic testing performed on May 12, 2004 revealed a normal right upper extremity. (Id) Dr. Strege diagnosed Petitioner with mild cubtial tunnel syndrome as well as probable radial tunnel syndrome. (Id) Dr. Strege specifically stated that Petitioner did not have signs of carpal tunnel syndrome. (Id) He recommended surgical intervention for cubital tunnel syndrome and radial tunnel syndrome, but Petitioner declined to have the procedure performed. (Id)

Petitioner did not receive any further treatment for his upper extremities until May 11, 2011, when he reported to Dr. George Paletta Jr. (Px 3, Rx 12) Petitioner underwent a repeat nerve conduction study on May 11, 2011, which indicated severe sensory and motor median neuropathy across the left carpal tunnel with axional involvement and mild residual findings on the right median nerve consistent with a previous carpal tunnel release. (Px 4, Rx 12) On June 16, 2011, Dr. Paletta performed a left elbow ulnar nerve transposition and a left-sided carpal tunnel release. (Px 3, Rx 12) Dr. Paletta opined that the surgical intervention yielded a good result in terms or resolution of the elbow and wrist symptoms, but Petitioner continued to describe a significant number of complaints involving his dorsal wrist. (Id) Dr. Paletta opined that these complaints were not directly related to the carpal tunnel. (Id) Petitioner also described tenderness in the classic location for intersection syndrome. (Id)

Petitioner reported to Dr. Young, his fifth treating upper extremity specialist, on November 8, 2011. (Px 9, Rx 14) Dr. Young noted complaints of numbness and tingling involving Petitioner's left upper extremity which Petitioner claimed had not improved since his recent left carpal tunnel release and ulnar transposition. (Id) Petitioner underwent a repeat nerve conduction study which showed compression in the areas where Petitioner had previously undergone surgical intervention. (Id) Petitioner last saw Dr. Young on October 23, 2012, at which time Dr. Young recommended a revision left carpal tunnel release and ulnar nerve revision. (Id)

The deposition of Dr. Young was taken on August 27, 2012. (P 13) During his deposition, Dr. Young testified that Petitioner's weight, smoking history, and alcohol consumption were all potential contributory factors for the development of carpal tunnel syndrome. (Id at 10) Dr. Young also testified

that Petitioner's age and hobby of working with horses could contribute to his development of upper extremity symptoms. (Id at 22-23) Dr. Young was presented with a list of job activities Petitioner claimed to perform during the course of his duties, and opined that the duties as described could have contributed to the development of carpal tunnel syndrome. (P 13 at 11-12) Dr. Young acknowledged that he did not know what portion of the day Petitioner spent writing or typing, and testified that the amount of time spent on those specific activities is relevant to his causation analysis. (Id at 24) Dr. Young acknowledged that he did not review the records of Dr. Chow, Dr. Ahn, or Dr. Strege. (Id at 20) Dr. Young testified that it is possible that Petitioner did not experience relief after his two previous surgical interventions because he does not in fact have carpal or cubital tunnel syndrome. (Id at 21)

Dr. Anthony Sudekum is a board certified plastic and reconstructive surgeon with an added qualification in surgery of the hand. (Rx 16) He is the owner and operator of the Missouri Hand Center, a hand specialty practice involved in the evaluation and treatment of patients with conditions affecting upper extremities. (Rx 16) On December 1, 2011, Dr. Anthony Sudekum performed an independent medical examination to assess Petitioner's upper extremity complaints. (Rx 15) Dr. Sudekum testified that he reviewed the records of Dr. Chow, Dr. Ahn, Dr. Emanuel, Dr. Strege, Dr. Paletta, and Dr. Young, as well as the job descriptions prepared by Petitioner. (Id at 18) Dr. Sudekum testified that Petitioner's age, obesity, smoking history, peripheral edema, and hobby of working with horses could all constitute potential comorbid factors for the development of carpal tunnel syndrome and cubital tunnel syndrome. (Id at 22, 23) Dr. Sudekum listed ten different upper extremity conditions with which Petitioner was diagnosed and indicated that such varied diagnoses indicated an inconsistent presentation of symptoms. (Id 24-26) Dr. Sudekum testified that Petitioner's variety and frequency of subjective complaints, when paired with his equivocal objective findings, indicate a pattern of symptom magnification. (Id at 27-29) Dr. Sudekum opined that, based on his understanding of Mr. Williams job duties, he did not believe that Petitioner's work played any role in the development or exacerbation of any upper extremity conditions. (Id at 36)

At his hearing, Petitioner testified that his symptoms had presented consistently. Petitioner indicated that he did not believe his diagnoses had changed very much over his ten years of upper extremity treatment. Petitioner denied being diagnosed with basal joint arthritis, basal joint synovitis, DeQuervain's, bilateral thoracic syndrome, radial tunnel syndrome, bilateral lateral epicondylitis, bilateral medical epicondylitis, or left intersection syndrome. Petitioner testified that his right sided surgery resolved his symptoms for four to five months. He testified that his experienced no relief after his left upper extremity procedure in 2011.

Therefore, the Arbitrator concludes:

1. Petitioner began his treatment for his bilateral upper extremity complaints on May 7, 2002 and terminated his treatment on June 28, 2004. By the time Petitioner filed his Worker's Compensation claim in 2011 and restarted his treatment, the statute of limitations had long since expired. 820 ILCS 305/6(d). Petitioner's testimony makes it clear that his condition was not resolved in 2004, as he only declined left sided surgical intervention in 2004 due to his fear of a painful surgical procedure. Petitioner's Application for Adjustment of claim

asserts that Petitioner was injured on May 11, 2011; however, there is no evidence that he sustained any identifiable injury on that date. To the contrary, Petitioner's testimony is replete with examples of the modernization of Respondent's facilities, all of which occurred well before 2011.

2. Even if this Arbitrator were to find that Petitioner's condition was resolved in 2004, which is contrary to his testimony, there is no evidence that he suffered an aggravation in 2011. Specifically, Petitioner has failed to demonstrate a causal nexus between his job duties from 2004 to the present and his upper extremity complaints. Petitioner went to great lengths to describe past office procedures and repeatedly indicated that his present duties are far less strenuous than his prior obligations. Petitioner's attempt to reach back in time to the office practices of the 1980's and 1990's is incompatible with the reaggravation theory of the case implied by his application for adjustment of claim. In order for Petitioner's case to be compensable and avoid the statute of limitations problems created by his 2002-2004 treatment, he must have a work related aggravation of his condition caused by the conditions at his work in 2011. By his own admission, the procedures at the Secretary of State's office had modernized by 2003, thereby making their prior procedures irrelevant to the case at hand. Furthermore, most of the hand intensive activities described by Petitioner involve handwriting and mouse use, which he acknowledged are not contributory to his left upper extremity treatment. Petitioner testified that his keyboard use is confined filling out forms, many of which are recalled from the database automatically with the entry of a driver's license number.

3. Petitioner failed to demonstrate that he suffered accidental injuries which were caused or aggravated by his job duties. Dr. Sudekum reviewed not only Petitioner's job analysis as well as the records of Petitioner's five treating upper extremity physicians. This makes Dr. Sudekum the only expert qualified to testify on the totality of Petitioner's medical history. Dr. Young testified that he had not reviewed the records of Dr. Strege, Dr. Chow, or Dr. Ahn. Dr. Young acknowledged that Petitioner may not have responded to his previous surgeries because he was not actually suffering from the pathology the surgeries were designed to remedy. As Dr. Sudekum pointed out; Petitioner has presented with no less than 10 different diagnoses from 5 different upper extremity physicians. Therefore, it is quite possible that symptom magnification is responsible for his inconsistent subjective complaints. There is simply no reason to expect that Petitioner's upper extremity complaints, which have failed to be resolved by any of his prior physicians or any of his prior surgeries, will be resolved by yet another surgical intervention.

4. Finally, an evidentiary issue was raised during the deposition of Dr. Sudekum regarding the admissibility of his opinions. This issue is now moot, as the opinions of Dr. Sudekum are also contained in his report, which was admitted into evidence without any objection from Petitioner's counsel.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Neunaber,
Petitioner,

vs.
Monterey Coal Company,
Respondent,

NO: 07 WC 38476
14IWCC0329

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, evidentiary error, legal error, permanent partial disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 1, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $42,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 2 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:4/24/17
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEUNABER, JAMES
Employee/Petitioner

Case# 07WC038476

14IWCC0329

MONTEREY COAL COMPANY
Employer/Respondent

On 3/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0755 CULLEY & WISSORE
BRUCE WISSORE
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
P O BOX 335
SPRINGFIELD, IL 62705

14IWCC0329

STATE OF ILLINOIS)
)SS.
COUNTY OF **Sangamon**)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Neunaber
Employee/Petitioner

v.

Monterey Coal Company
Employer/Respondent

Case # **07** WC **38476**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **2/04/2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Did the Petitioner develop an occupational lung disease as a result of exposure in the course of his employment with Respondent?**

FINDINGS

On **9/30/06**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner was last exposed to the coal dust and fumes arising out of and in the course of employment.

Timely notice of this exposure ***was*** given to Respondent.

Petitioner's condition of ill being is causally related to his occupational exposures.

In the year preceding the last date of exposure, Petitioner earned **$49,200.84**; the average weekly wage was **$946.17**.

On the date of last exposure, Petitioner was **56** years of age, ***single*** with **no** dependent children.

ORDER

Respondent shall pay the Petitioner the sum of $567.70 for 75 weeks, as the injuries resulted in a loss of 15% under section 8 (d) (2) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator KM

2/22/13
Date

MAR 1 - 2013

Petitioner, James Neunaber, was born on 2-18-50 and was 62 on the date of arbitration. He coal mined for 35 years, 34 of which were underground. All of his coal mining occurred at Respondent Monterey Coal Company's Carlinville Mine where he was regularly exposed to coal and silica dust, roof bolting and plant glues, and diesel fumes. Petitioner was 57 and working as a Laborer when last occupationally exposed on 9-30-06. Petitioner stated that Monterey was going to sell the company, and he retired because he needed to secure insurance because of his health. Petitioner did not seek employment after he left mining because he felt his lungs "were shot." He did not look for work after leaving the mine, and his prior work involved manual labor.

About 10 years before he retired, Petitioner began noticing breathing problems while mine examining in dusty areas or when around diesel fumes. At times he had to stop his rounds and rest even though he was under time pressures to complete his rounds. Sometimes he had to get down on his hands, elbows and knees and hold his head for a while to breathe and rest before he could continue. During his last years as an examiner temporary examiners had to finish his rounds when he was having a bad day.

In addition to being a laborer, Petitioner operated the continuous miner for twelve years. He bid out of that job to be a mine examiner hoping to have less dust exposure away from the face, but he was examining in dusty entries most of the time. There was always diesel exposure from the vehicle he drove, as well as shield haulers, scoop tractors, and mules. He was exposed to roof bolting glue fumes because he had to examine the freshly bolted areas. Old glue tubes were often discarded and run over by machinery in the mines. Glue and diesel fumes made him short of breath, and he had to leave the area sooner than he should have.

Currently, Petitioner cannot walk very far without becoming breathless. He cannot climb stairs, or visit good friends who live in an upstairs apartment. His breathing problems have progressively worsened, and he has been on 24 hour oxygen since December 18, 2012. Petitioner does not leave the house unless he has to. He hires someone to do his yard work. His step daughter and a friend help him keep his house clean. Petitioner has a small cottage by a lake, but his activity there is limited to watching TV, getting something to eat, and looking out on the lake while he sits. He has been unable to ride a motorcycle for many years. He no longer hunts or fishes and has given his equipment to his kids. After retirement, he did build a cabin at his home, but testified that the work was contracted to others.

Petitioner smoked from age 20 until he went on 24 hour oxygen, but still has one once in a while with a cup of coffee. He testified that he had smoked a pack, maybe two, a day. There were not many hours in the day to smoke because it was not allowed at work, and sometimes he worked 12-20 hour days. He further admitted that he continued to smoke long after he began treatment for pulmonary problems. His treating doctor's notes reflect that he reported smoking two packs a day as late as March 5, 2009. (RX 3)

Petitioner called two longtime co-workers from the Carlinville Mine. David Martioni, a personal friend, saw Petitioner when he examined areas of the mine where he was working. Even when Petitioner was not examining, Mr. Martioni saw him on a daily basis as he left the mine. Mr.

Martioni stated that Petitioner used to be a workhorse, but during the last couple years at the mine Petitioner was unable to finish his routes, and back up examiners had to be called in. He opined that the Petitioner's quality of life has significantly deteriorated since he began his mining career. By the end of the work day Petitioner's physical condition was very poor.

Dick Schulte worked as a roof bolter in Petitioner's unit in the late 1980's while Petitioner was a mine examiner. After he changed to out-by work, Mr. Schulte saw Petitioner on the roadways as he was examining. Later as a repairman he saw Petitioner when he required his unit to make gas checks. Mr. Schulte noticed Petitioner on the roadways leaning and having breathing problems. He would stop to see if Petitioner needed help. Petitioner would have to sit and rest in his unit at times before he could travel on. He said that during the last year of Petitioner's mining career he could not do near the amount of work he'd done previously and had to walk slowly to his car when work was over.

Dr. Chopra, Petitioner's treating physician, has practiced general and family medicine in Carlinville since 1981. Ten to fifteen percent of his patients are coal miners, and he treats miners for pulmonary disease. Dr. Chopra has treated Petitioner since the early 1990's and has done many examinations and patient histories and had chest x-rays and pulmonary function testing performed. Dr. Chopra has had Petitioner on pulmonary medications for many years, including nebulizer treatments and ProAir and Symbicort inhalers. (PX 2, p. 5-6). Dr. Chopra testified that Petitioner has a history of cough and has had shortness of breath and pulmonary limitations for quite some time. Dr. Chopra felt Petitioner had coal workers' pneumoconiosis (CWP). Petitioner also has moderate to severe COPD and chronic bronchitis. After seeing Petitioner's testing showing a 19% drop on his Methacholine testing, Dr. Chopra agreed that there is an asthmatic component in Petitioner's condition and that coal mining was a contributor. (PX 2, p. 8-11, 17). Based on each of Petitioner's pulmonary diseases, exposure to the coal mine environment would risk his health. Petitioner does not have the pulmonary capacity to do the work of a coal miner or work requiring manual labor. Petitioner condition has become slightly worse, but smoking and obesity were contributors. (p. 11-12).

Dr. Chopra stated that Petitioner smokes between one and two packs of cigarettes a day, and has been counseled about that habit. Petitioner who is 5'7" now weighs 262 pounds and in June of 2006 he weighed 193. (PX 2, p. 13-15). The main contributing factor to Petitioner's COPD and chronic bronchitis is smoking. It could also contribute to his asthmatic bronchitis. (p. 17-18). Dr. Chopra was asked about records from 2010 and 2011 where Petitioner denied shortness of breath. He stated they are incorrect because Petitioner had shortness of breath. He explained that any findings of clear lungs would depend on how well Petitioner's medicine was working at the time, but that most of the time he would find wheezing. He did not feel that Petitioner's cardiac problems had any effect on his breathing. However he stated that Petitioner's lung problems can cause an extra burden on his heart function. (p. 19-21).

Dr. Chopra's records were introduced, and showed some back problems, and numerous entries regarding COPD, the use of inhalers and nebulizers, symptoms such as shortness of breath, or denials thereof, cough, and physical findings, such as wheezing, rhonchi and crepitations; his smoking consumption is also documented. (PX 7, p. 2, 5, 7, 9, 10, 12, 31, 33-34, 36, 38-39, 41--45, 47, 49, 51, 53, 55-58, 61-70, 110). The records show an exacerbation of obstructive chronic bronchitis on 3-9-07. (PX 7, p. 45-46). By 12-29-11 Petitioner's work capacity was diminishing, as carrying a bag of groceries caused chest tightness and shortness of breath. Yet, the entry

states he denied shortness of breath or chest tightness, which gives some credence to Dr. Chopra's view of such entries. (PX 7, p. 59). Stress testing on 3-24-09 from Prairie Cardiovascular showed normal perfusion imaging and wall motion, normal left ventricular systolic function, and no ischemia or previous infarction. (PX 7, p. 91-93). Pulmonary function testing of 3-17-09 reported moderately severe obstructive lung disease with low CO diffusions compatible with loss of the pulmonary capillary bed. (PX 7, p. 95). Further cardiac testing of 1-12-12 showed no significant change from the 3-24-09 study, and there was a low probability for coronary disease. (PX 7, p. 108-109). A chest x-ray of 3-17-09 for shortness of breath and chest pain reported chronic lung disease with some fibrosis and emphysema. There was mild interstitial fibrosis. Scarring in the right middle lobe also was noted. There was no change with the mild interstitial fibrosis after a 6 ½ month interval. (PX 7, p. 120). A chest film of 12-17-11 for cough noted a smoking and mining history. It reported mild fibrotic changes. (PX 7, p. 124).

Respondent also submitted records from Dr. Chopra which contained additional older entries. (RX 3). There are abundant references in the records to wheezing, notations of COPD, bouts of bronchitis requiring medication, and some complaints of shortness of breath and cough. The following dates have relevant entries pertaining to pulmonary issues: 6-3-08, 11-19-07, 8-23-07, 5-25-07, 2-23-07, 7-25-06, 6-26-06, 2-27-06, 11-7-05, 8-11-05, 6-24-05, 5-23-05, 1-21-05, 9-4-03, 6-4-03, 3-12-03, 3-3-03, 12-26-02, 10-23-02, 9-19-02, 10-11-01, 10-4-01, 7-30-01, 7-18-01, 12-1-00, 9-7-00, 6-30-00, 3-16-99, 7-20-98, 3-6-98, 7-14-98, 10-7-97, 9-22-95, 11-1-95, and 9-13-95. An x-ray of 8-6-07 showed stable scarring at the right base. A film of 7-24-06 showed stable bibasilar scarring or atelectasis and findings consistent with COPD. A chest x-ray of 5-20-05 showed linear atelectasis in the right lung base. There was no significant change from a 5-12-04 film. The film of 5-12-04 noted some COPD and fibrosis. A 10-21-02 x-ray showed mild COPD changes. A 7-30-01 film was normal.

Carlinville Area Hospital records show some shoulder problems, heart problems, COPD, the complete pulmonary function testing of 3-17-09, and Petitioner's smoking consumption. (PX 6, p. 7, 29, 32-53, 57, 98, 102-104, 137). Many entries are duplicative of Dr. Chopra's records. A chest x-ray for COPD and cough of 8-26-08 reports no change from the past year with moderate emphysema. (p. 58). A chest x-ray for cough from 7-24-06 reports stable bibasilar scarring or atelectasis and findings consistent with COPD with no change from prior chest films. (p. 99).

Memorial Medical Center Records show treatment for Petitioner's heart, back surgery, and rollover accident, during which he had pneumonia. Of relevance are entries showing respiratory complaints and treatments during these hospitalizations. (PX 8, p. 5, 78, 89, 109, 112, 113, 116, 156, 204, 242, 245, 331, 343, 360, 363, 391-394, 397, 402, 418, 425-426, 442-443, 455, 457, 465, 473-474, 477, 481, 489, 495).

Dr. Glennon Paul examined Petitioner at his attorney's request on 2-19-08. Dr. Paul is the Medical Director of St. John's Hospital Respiratory Therapy Department and teaches internal and pulmonary medicine at SUI Medical School. He is the senior physician at the Central Illinois Allergy and Respiratory Clinic which employs six physicians specializing in allergy and pulmonary diseases. He has authored a book on Asthma. His patient census has 50,000 people, and he reads about 5000 chest x-rays and pulmonary function studies each year. Dr. Paul has examined coal miners for federal and state black lung claims, the vast majority of which were for coal companies. (PX 1, p. 6-8). Dr. Paul reported Petitioner had a 10 year history of shortness of breath which was worsening. He becomes breathless after walking a mile or ascending 4 flights

of stairs. Petitioner gets bronchitis with upper respiratory tract infections which are usually treated with antibiotics. Petitioner was a 40 year pack a day smoker. Petitioner's chest exam was normal, and his chest x-ray showed small nodules throughout both lung fields and early fibrosis. Dr. Paul felt that Petitioner had CWP and asthmatic bronchitis, also known as reactive airways disease (RAD). (PX 1, Paul Report; PX 1, p. 9).

Dr. Paul stated that because Petitioner has RAD, his pulmonary function test results will vary depending on how his RAD is on the day of testing. On some days he could be totally disabled because of his lungs, and on others he could generate better test results. (PX 1, p 12). Under the AMA guidelines Petitioner's diffusing capacity of 52% of predicted would rate as a moderate physical impairment. (PX 1, p. 15). The diffusing capacity measures the lungs' ability to transport oxygen. (PX 1, p. 13).

Dr. Paul opined that the 3-17-09 pulmonary function testing from Carlinville Medical Clinic demonstrated obstruction with an FEV1 of 2.28, decreased from his FEV1 of 2.80. The diffusing capacities were similar, but the 10% increase in FEV1 after bronchodilator administration confirmed his diagnosis of RAD. (PX 1, p. 17-18). Dr. Paul stated that Petitioner's exposures to glue fumes in the mines could cause or aggravate Petitioner's RAD. (PX 1, p. 20). He provided that coal mine and silica dusts and diesel and glue fumes in the mines all can harm the lungs, and that mining exposures can cause occupational asthma. (PX 1, p. 35, 38). Dr. Paul agreed that smoking does not cause RAD, but can trigger or aggravate asthma and aggravate asthmatic bronchitis. (PX 1, p. 48, 61). The RAD aggravation would be both temporary and permanent. (PX 1, p. 51).

Based on Petitioner's environmental restrictions and his inability to do manual labor, Dr. Paul felt Petitioner was permanently and totally disabled from coal mining. Dr. Paul felt he was capable of light to medium labor, but because of his RAD there would be days when he would be unable to work at all. (PX 1,p. 24).

B-reader/Radiologist, Dr. Michael Alexander, interpreted Petitioner's quality one chest x-ray of 6-7-07 as positive for CWP in all lung zones, category 1/1. (PX 4).

At Respondent's request, Petitioner was examined by Pulmonologist Dr. Peter Tuteur on 10-14-10. (RX 1, p. 5). Dr. Tuteur was also provided with Dr. Paul's report, Dr. Alexander's B-reading, a 3-24-09 exercise study, a 3-17-09 pulmonary function test, and serial chest x-ray reports from Carlinville Area Hospital. Dr. Tuteur stated that Petitioner's breathlessness required him to stop after walking ¾ of a mile or climbing 2-3 flights of stairs. Petitioner had a cough throughout the day occasionally associated with sputum, and nocturnal wheezing associated with heartburn. Dr. Tuteur reported Petitioner's treater "has offered Symbicort and ProAir, which he is unable to identify whether or not it helps. He has not required hospitalizations for exacerbations, nor has he clearly had even minor exacerbations." Dr. Tuteur stated that the Petitioner was obese, a factor which could cause a reduction in the Petitioner's lung capacity.

According to Dr. Tuteur, after Petitioner was stented, his breathlessness improved. Petitioner's physical exam was normal. There was no evidence of CWP on Petitioner's chest film. (Tuteur report, p. 2). Dr. Tuteur felt that his pulmonary function studies and those of Dr. Paul and Carlinville Hospital showed no worse than a very minimal obstruction that did not improve after bronchodilator. He blamed the decreased diffusing capacities on exaggerated predicted values because of obesity, concluding that the diffusing capacity was essentially normal. Pulmonary

function testing demonstrated a mild obstructive ventilatory defect which did not improve with bronchodilator. Dr. Tuteur concluded that Petitioner had chronic bronchitis and an associated mild obstruction which he blamed on smoking. He felt that if Petitioner had never coal mined his clinical picture would be the same. (Report, p. 3).

Dr. Tuteur testified that Petitioner told him after he retired he built his cabin primarily by himself, contracting some work out. (RX 1, p. 6-7). This is inconsistent with Petitioner's testimony. Dr. Tuteur felt that Petitioner's weight gain would cause shortness of breath. (p. 10). He rated Petitioner's chronic bronchitis and air flow obstruction as clinically insignificant. (p. 14-15). He did not believe Petitioner had any bronchial reactivity based on the Methacholine test, because a positive result requires a 20% change, and Petitioner's was 19%. (p. 18).

On cross-examination Dr. Tuteur stated that coal mine dust can cause shortness of breath and a cough. The tissue reaction caused by CWP is permanent fibrosis or scarring and focal emphysema. The affected tissue cannot function and if there is enough scarring measurable impairment results. One can have CWP with normal pulmonary testing and physical exams. Dr. Tuteur recommends that those with CWP avoid any further dust exposure. (RX1, p. 19-23). Dr. Tuteur conceded that pulmonary function testing cannot determine the cause of an abnormality. (RX 1, p. 28)

He testified that the most common cause of chronic bronchitis was cigarette smoke, but acknowledged that coal dust could also be a cause. In discussing the relative risks in his narrative report, Dr. Tueter said that the risk of the Petitioner developing his problem from cigarettes was 20 %, while the risk from coal mining was at 1 %. He acknowledged that the American Thoracic Society finds a greater comparison between the effects of coal dust and smoking than he does, placing the coal kjine risk at 4 %. He has not published his disagreement with their views. (RX 1, p. 31-33). Dr. Tuteur is familiar with the December 2000 review of medical literature by NIOSH and the DOL published in the Federal Register. The agencies' findings after a review of the literature also conflicts with Dr. Tuteur description of relative risks of smoking and coal dust. Dr. Tuteur has not published his disagreement with their conclusions either. (PX 1, p. 34-35). Dr. Tuteur acknowledged that the inhalation of silica dust as a component of coal mine dust can cause an obstructive defect, or aggravate an obstruction caused by something else. (p. 38).

Dr. Tuteur agreed that Petitioner was exposed to sufficient amounts of coal mine dust to cause obstructive lung disease or a decreased diffusing capacity in a susceptible host. A decreased diffusing capacity is consistent with CWP. (RX 1, p. 49-50). Dr. Tuteur blamed smoking for Petitioner's obstruction because of his view of statistical probabilities. However, he agreed that coal mine exposures could, to a very small degree, be a cause of Petitioner's chronic bronchitis, COPD, and reduced diffusing capacity. He agreed that not all smokers with Petitioner's history develop obstruction, chronic bronchitis, or coronary artery disease. (p. 55-56). Dr. Tuteur conceded that he would blame Petitioner's chronic bronchitis on mining if Petitioner never smoked. (RX 1,p. 58). Chronic coal mine dust inhalation can produce a clinical picture that is indistinguishable from smoking induced COPD. (RX 1, p. 36-37).

Dr. Tuteur agreed that diesel fumes can affect lung function and cause bronchial reactivity, and that roof bolting glue fumes can harm the lungs and cause RAD. (RX 1, p. 36, 47, 49). Dr. Tuteur conceded that wheezing is consistent with bronchial reactivity. As already indicated,

Petitioner's medical records document a history of wheezing. Petitioner's medications are prescribed for air flow obstruction diseases including bronchitis, emphysema, chemically induced bronchial reactivity or asthma. (p. 51). Dr. Tuteur also stated than an obstruction on pulmonary testing can be consistent with chemically induced bronchial reactivity. (p. 52). If Petitioner had chemically induced bronchial reactivity he should not return to environments that aggravate it. (p. 75).

Respondent also submitted B-reader/radiologist Dr. Wiot's negative interpretation of Petitioner's 10-14-10 chest film. Dr. Wiot commented only on Petitioner's spine and aorta. (RX 2).

Delores Gonzalez, a vocational rehabilitation counselor (PX3, p. 4) evaluated the Petitioner on 5/24/12 (PX13, p. 6). She obtained a personal history and a vocational history from the Petitioner (PX3, p. 7-8). She reviewed medical records and did a transferability of skills analysis (PX3, p. 8). She also did some vocational testing on the Petitioner (PX3, p. 10). Ms. Gonzalez concluded that the Petitioner might be able to find a job making $8.50 to $10.00 per hour. However, she indicated that employers usually favor younger individuals who are more work-ready with higher academic skills (PX3, p. 12). Ms. Gonzalez testified that she was not helping the Petitioner find work, with a job search or preparing a resume (PX3, p. 14). As of 5/24/12, the Petitioner was living by himself and caring for himself. He was not looking for work and had not looked for work since his retirement from Respondent (PX3, p. 16).

Conclusions of Law

By all accounts, the Petitioner has diagnosed pulmonary diseases. Dr. Paul testified that he has coal miners' pneumoconiosis and asthma or reactive airway disease. Dr. Tueter testified that the Petitioner had chronic bronchitis and a minimal obstructive abnormality based upon the pulmonary function studies which he ordered. Dr. Chopra, who has treated the Petitioner since 1994, diagnosed moderate to severe chronic obstructive pulmonary disease, restrictive asthma and likely pneumoconiosis. The B-Reader hired by the Petitioner saw CWP on one X-ray, and the B-Reader hired by the Respondent indicated there was none on another X-ray.

Most important to the Arbitrator on the issue of whether a disease or diseases exist are the records of Dr. Chopra. His records support the Petitioner's testimony that his problems have been long standing and consistent. Since 1994, Dr. Chopra has repeatedly diagnosed acute and chronic bronchitis and chronic pulmonary disease based upon the Petitioner's symptoms of coughing and shortness of breath and exam findings of bilateral crepitation, wheezing and rhonchi. While it is true, as the Respondent points out, that the Petitioner did not complain of shortness of breath on every office visit, the doctor's examinations, on

most occasions, revealed the three findings referred to above consistent with the diagnoses. Since that time, the Petitioner has been on numerous medications for his conditions.

The fact that the Petitioner had a long history of treatment for his pulmonary disease distinguishes this case from numerous cases decided by the Commission over the past several years dealing with simple coal miners' pneumoconiosis. See Young v. Freeman United, 12 IWCC 182; Sims v. Freeman United, 12 IWCC 586; Carpenter v. Monterey Coal, 11 IWCC 1120. The facts here more resemble those in Phelps v. Monterey Coal, 11 IWCC 804. There, the Petitioner, a smoker, had a long history of bronchitis, coughing and wheezing for which he received regular medical care.

Based on all the above evidence, the Arbitrator finds that the Petitioner suffers from CWP. The treatment x-ray report of 3-17-09 notes mild interstitial fibrosis, and the film of 2-17-11 reports mild fibrotic changes. (PX 7, p. 120, 124). These findings are consistent with CWP. Dr. Tuteur's film taken in 2010 was interpreted by Dr. Wiot and Tuteur as showing no fibrosis, which seems at odds with the two aforementioned films. In addition, the chest film of 5-20-04 noted fibrosis and post inflammatory calcifications, and other films report scarring in the bases, bibasilar scarring, or atelectasis in the right base. (RX 3, 8-6-07, 7-24-06, 5-20-05). Petitioner's experts and Dr. Chopra both concluded that Petitioner had CWP and I find their opinions more credible.

The issue then becomes whether any or all of the various diagnoses are causally related to the Petitioner's mine exposures, which the parties stipulated were present. (Arb. X1) The Arbitrator notes that the occupational exposure need not be the sole or even predominant cause of the condition, so long as it is a cause. "The occupational activity need not be the sole or even the principal causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. **Gross v. IWCC, 2011 IL App (4th), 100615WC, ¶22.** The fact that the Petitioner has an extensive smoking history and is obese does not negate the argument that his mine exposures contributed to any or all of his conditions.

The Arbitrator disagrees with the opinions of Dr. Tueter concerning the two conditions which he diagnosed, chronic bronchitis and obstructive lung disease. In his narrative report attached to his deposition, the doctor discussed the issue of causation. He concluded that smoking was a causative factor because the known risk of developing the conditions from smoking was higher than the known risk from exposure to coal dust. He did, however, acknowledge the fact that there were known risks from each activity. In referring to the Petitioner's condition, the doctor wrote "Though this symptom complex potentially can be caused by chronic inhalation of coal

mine dust, in this case based upon the approximate 20% risk for the development of cigarette smoke induced pulmonary disease and the approximate 1% risk of development of coal mine induced legal coal workers pneumoconiosis..." the problem was caused by one and not the other. He never explained why the mining risk, albeit slight, was not a contributing factor to the conditions. The Arbitrator believes his rationale, described above represents a misunderstanding of our above stated law on causation.

The opinions of Dr. Chopra, Petitioner's long-time treater, and Dr. Paul were more credible than Dr. Tuteur regarding Petitioner's occupational lung diseases. While acknowledging that the conditions were due to several factors, both testified that Petitioner's coal mining exposures caused, contributed or aggravated his COPD and chronic bronchitis.

On the issue of nature and extent, the Arbitrator again looks to the testimony and records of Dr. Chopra and Dr. Paul. At his deposition taken April 12, 2012, Dr. Chopra opined that the Petitioner could no longer work in the mine. No doctor testified to the contrary. He also said the Petitioner should not perform work requiring manual labor. He also said that over the past several years the Petitioner's condition might be getting a little worse. His follow up treatment notes for 2012 do not show any unusual visits. They are consistent with what one would expect for a person with reactive airways being treated appropriately with medication. Dr. Paul testified on February 15, 2010 that the Petitioner was mildly to moderately impaired. He opined that the petitioner could perform light to medium work, but would have to miss work during periods when his asthma was flared up. (PX 1 at 24) While Dr. Chopra's records since then show an ongoing diagnosis of COPD, there does not appear to be any entries consistent with an asthma flare-up. It should also be noted that Dr. Paul gave his opinions on the Petitioner's ability to work after discussing the pulmonary function studies of March 2009 which showed airway reactivity.

The vocational expert Ms. Gonzalez testified that the Petitioner could perform unskilled sedentary work. While she referenced Dr. Paul's opinions concerning the Petitioner being able to perform at a higher level, she does not explain her basis for assuming sedentary limits. The Arbitrator believes that affects her opinion, and as such, does not believe that the evidence is sufficient to support an award under Section 8 (d) (1).

Looking again at the Phelps case referenced above, along with the Commission decision in Irvin v. Consolidated Coal, 7 IWCC 263, the Arbitrator awards 15% Person as a Whole pursuant to Section 8 (d) (2) of the Act.

Dated and Entered February 21, 2013

D. Douglas McCarthy, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Van Note,
Petitioner,
vs.
Freedom Oil,
Respondent,

NO: 07 WC 12874

14IWCC0330

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, benefit rates, causal connection, medical expenses, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2012 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 2 2014

MB/mam
O:4/24/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VAN NOTE, LORI
Employee/Petitioner

Case# **07WC012874**

14IWCC0330

FREEDOM OIL
Employer/Respondent

On 12/7/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0724 JANSSEN LAW CENTER
JAY H JANSSEN
333 MAIN ST
PEORIA, IL 61602

0740 THIELEN FOLEY & MIRDO LLC
JOSEPH W FOLEY
207 W JEFFERSON ST SUITE 600
BLOOMINGTON, IL 61701

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LORI VAN NOTE,
Employee/Petitioner

v.

FREEDOM OIL,
Employer/Respondent

Case # 07 WC 12874

Consolidated cases: NONE.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **July 12, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other: _____

14IWCC0330

FINDINGS

On **February 16, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this alleged accident *was* given to Respondent.

Petitioner's current condition of ill-being *is in part* causally related to the alleged accident.

In the year preceding the alleged injury, Petitioner earned **$6,288.73**; the average weekly wage was **$330.99**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **no** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $ **46,899.30** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **46,899.30**.

Respondent is entitled to a credit of $ **0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$220.66**/week for **57-5/7** weeks, commencing **March 2, 2007** through **April 11, 2008,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$198.59**/week for **62.5** weeks, because the injuries sustained caused the **12.5%** disability to her **person as a whole**, as provided in Section 8(d)2 of the Act.

Petitioner is now entitled to receive from Respondent compensation that has accrued from **February 16, 2007** through **July 12, 2012,** and the remainder, if any, of the award is to be paid to Petitioner by Respondent in weekly payments.

Respondent is entitled to receive a credit for medical benefits paid in the amount of **$191,585.28.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator **JOANN M. FRATIANNI**

December 3, 2012
Date

DEC - 7 2012

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner testified that she was employed as an assistant gas station manager. Her job duties included paperwork, stocking shelves, cleaning, counting and sorting. Petitioner testified that on February 16, 2007, a co-worker was ill so Respondent's owner requested that she take the daily deposit to the local bank by 2:00 p.m. As she exited the store and while walking to her head manager's vehicle in the parking lot, she slipped on ice and snow and fell onto her buttocks, back and struck her head. Petitioner testified that immediately after this fall, she became numb, cold and sore. She then managed to get to her feet, drove to the bank to make the deposit, and returned to the station and finished her work shift. Petitioner testified that she noticed her back and buttocks were sore.

Later that evening, Petitioner sought treatment at the emergency room of OSF St. Joseph Medical Center. A history was recorded of a falling and twisting injury two days ago and another history that she had slipped four times over the past two days. A history was also recorded of slipping on ice while at work to her treating physician, Dr. Kattner, on March 15, 2007.

Based upon the above, the Arbitrator finds that the histories provided to the above medical providers corroborate Petitioner's testimony. As a result, the Arbitrator further finds that Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent on February 16, 2007.

F. Is Petitioner's current condition of ill-being causally related to the injury?

See findings of this Arbitrator in "C" above.

Petitioner testified that prior to this fall she experienced no lower back or leg pains or problems. She further denied any treatment to her lower back or legs prior to this fall.

Petitioner did in fact experience symptoms to her lower back and legs prior to February 16, 2007. Petitioner saw Dr. Santiago, who performed a hysterectomy and laproscopy. She reported back pain to him in 2003, 2004, and 2005. She also reported back pain on August 7, 2003 to Dr. Santiago and related it to a surgery from June of 2003. (Rx4) On February 9, 2007, Petitioner reported sharp back pain and radiating pain along with a prior history of leg and ankle swelling in an emergency room visit at OSF St. Joseph Medical Center. (Px1)

On February 16, 2007, at the same emergency room, she provided a history of a prior back injury and back pain (Px1) and repeated the same history when seen in the emergency room of BroMenn Hospital on February 25, 2007. While at BroMenn she reported back pain down both legs for two years. Later during that same visit, a history was provided by her husband of back pain from a fall two weeks earlier. Petitioner was instructed to see Dr. Kattner, a neurosurgeon. (Rx2)

Petitioner saw Dr. Kattner on March 15, 2007 and reported having slipped on ice at work. She complained of severe low back pain radiating to both hips and legs. Dr. Kattner reviewed an MRI performed on February 25, 2007, and felt there was no significant pathology other than disc bulging and mild degenerative changes. During examination, no significant deficits were noted. Dr. Kattner felt that Petitioner would not improve with surgical intervention and referred her to see Dr. Jhee for pain management. (Px2, Rx3)

Petitioner saw Dr. Jhee on May 7, 2007, who noted the mild degenerative changes on the MRI. Dr. Jhee prescribed physical therapy that was performed through June 11, 2007. Dr. Jhee then prescribed an EMG/NCV study that was performed on June 22, 2007. The EMG/NCV failed to show any evidence of an active and ongoing lumbosacral radiculopathy. Dr. Jhee felt that the pain was more muculoskeletal in origin including sacroiliac joint disfunction. Dr. Jhee prescribed a right S1 joint injection that was administered that same day. During a visit on July 23, 2007, Petitioner felt the injection was quite helpful, and was prescribed home exercises. Petitioner was released to return to work with restrictions effective August 1, 2007. Dr. Jhee decreased the restrictions and by November 20, 2007 she was allowed to lift up to 35 pounds with no frequent bending or twisting.

On March 29, 2008, Petitioner was admitted to OSF St. Joseph Medical Center for chronic lower back pain. A lumbar MRI performed the day before failed to reveal any disc herniation or protrusion throughout the lumbar spine. Petitioner received bilateral S1 joint injections, was noted to be ambulating freely and was discharged on March 31, 2008. At that time she came under the care of Dr. Mulconrey. (Rx3)

On April 11, 2008, Petitioner saw Dr. Salehi at the request of Respondent. Dr. Salehi following a record review and examination concluded that Petitioner may have sustained an injury during the fall in the form of a lumbar strain, S1 joint dysfunction or temporary exacerbation of a pre-existing degenerative disc disease. He concluded the low back pain was more likely the result of the pre-existing degenerative disc disease from L3-L4 through L5-S1. Finally he felt she had reached maximum medical improvement for any lumbar strain and recommended a bilateral S1 joint rhizotomy given her prior positive responses to S1 joint injections. He felt that she would reach maximum medical improvement within four weeks after the rhizotomy, and then be able to return to work. (Rx1)

Petitioner came under the care of Dr. Nord, an orthopedic surgeon. On November 25, 2008, Dr. Nord performed surgery in the form of a left knee arthroscopy with medial meniscal tear repair. (Px9) Dr. Nord testified by evidence deposition (Px11) that the knee problems and surgery were in his opinion causally related to the fall that occurred according to Petitioner in September, 2008. He felt that her knee symptoms were separate from any sciatic pain stemming from her back issues. Dr. Nord was never provided a history of injury occurring on February 16, 2007.

On January 20, 2009, Petitioner underwent surgery with Dr. Mulconrey in the form of a posterior lumbar interbody fusion at L5-S1 with decompression, bilateral hemilaminectomy with partial facetectomy and foraminotomy. (Px5) Post surgery, Petitioner was released at maximum medical improvement by Dr. Mulconrey on October 5, 2009. (Px5)

On November 17, 2010, Petitioner was seen in the emergency room of OSF St. Joseph Medical Center for bilateral ankle and right knee complaints after stepping off a car deck and loading a trailer an hour earlier. At that time her right leg buckled causing her to fall to the ground on her right side. (Rx5) Petitioner also provided a similar history to Dr. Spaniol at OSF St. Joseph Medical Center in that she felt her right knee cap popped out of place. (Rx7) Petitioner later underwent right knee anterior cruciate ligament reconstruction with allograft insertion with Dr. Keller on December 10, 2010. (Px1)

Based upon the above, the Arbitrator makes several findings: (1) that Petitioner has proven that a causal relationship existed between the lumbar sprain sustained in her fall on February 16, 2007; (2) that Petitioner has proven that a causal relationship existed between the S1 joint dysfunction and the fall of February 16, 2007; (3) that Petitioner reached maximum medical improvement from the lumbar sprain and the S1 joint dysfunction as of November 20, 2007, while under the care of Dr. Jhee; (4) that the left knee surgery performed at a later date Dr. Nord is not causally related to the fall of February 16, 2007; (5) that the right knee surgery performed at a later date by Dr. Keller is not causally related to the fall of February 16, 2007, and finally; (6) that the lower back surgery performed on January 20, 2009 is not causally related to the fall of February 16, 2007.

G. What were Petitioner's earnings?

The only evidence presented at trial as to this issue was a wage statement introduced by Respondent. (Rx9) The wage statement revealed a 19 week history of earnings of $6,288.73 which preceded February 16, 2007.

Based upon this evidence, the Arbitrator finds the earnings for the year preceding February 16, 2007 to be $6,288.73, which results in an average weekly wage of $330.99.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

See findings of this Arbitrator in "C" and in "F" above.

Based upon said findings, the Arbitrator further finds that all medical charges incurred prior to April 11, 2008, the date of Dr. Salehi's examination, represent reasonable and necessary care related to the cure or relief of the injury sustained in this case.

The parties have stipulated that those charges were paid by Respondent and the total payments were $191,585.28.

All other medical charges incurred after that date are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "F" above. Petitioner as a result of this accidental injury lost time from work commencing March 2, 2007 through April 11, 2008.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner became temporarily and totally disabled from work commencing March 2, 2007 through April 11, 2008, and is entitled to receive compensation from Respondent for this period of time.

L. What is the nature and extent of the injury?

See findings of this Arbitrator in "C" and "F" above.

Petitioner testified that she has not worked since March 2, 2007, has not sought employment since that time and was eventually terminated from her job in August, 2008.

Based upon said findings, the Arbitrator finds the above condition of ill-being in the form of a lumbar strain and an S1 joint dysfunction to be permanent in nature.